in the

Supreme Court

of the

United States

OCTOBER TERM, 1978

NO. 78-88

DR. JOHN T. MACDONALD FOUNDATION, INC., d/b/a Doctors' Hospital, a Florida corporation not for profit,

Petitioner,

v.

JOSEPH CALIFANO, Secretary of Health, Education & Welfare, BLUE CROSS ASSOCIATION, an Illinois corporation, and BLUE CROSS OF FLORIDA, INC., a Florida corporation,

Respondents.

PETITION FOR A WRIT OF CERTIORARI

To the United States Court of Appeals for the Fifth Circuit

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STATUTES* AND REGULATIONS (Continued)

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The DR. JOHN T. MACDONALD FOUNDATION, INC., d/b/a Doctors' Hospital [hereinafter referred to as the HOSPITAL] respectfully prays that a writ of certiorari issue to review the *en banc* judgment of the United States Court of Appeals for the Fifth Circuit entered in this proceeding on April 17, 1978.

OPINIONS BELOW

Three opinions were written by the Court of Appeals in this case. The final *en banc* opinion, reported at 571 F.2d 328, is appended hereto as Exhibit A. The second opinion is reported at 554 F.2d 714 and a copy is appended hereto as Exhibit B. The first opinion of the Court of Appeals is reported at 534 F.2d 633 and a copy is appended hereto as Exhibit C. The second and third opinion followed from successive petitions for rehearing filed by the Secretary of Health, Education and Welfare [hereinafter referred to as the SECRETARY].

The opinion of the District Court is not reported and a copy is appended hereto as Exhibit D. At the administrative level there were two opinions, one covering the HOSPITAL'S fiscal years 1967-68 and the other covering its fiscal years 1969-72. Copies of these unreported opinions are appended hereto as Exhibits E and F, respectively.

JURISDICTION OF THE SUPREME COURT

The judgment of the Court of Appeals for the Fifth Circuit was dated and entered April 17, 1978. No further petition for rehearing was filed and the time for filing such a petition expired on May 1, 1978. This petition was filed within 90 days of the entry of judgment by the Court of Appeals and this Court's certiorari jurisdiction is invoked under 28 U.S.C. §1254(1).

QUESTION PRESENTED

For hospital accounting periods ending prior to June 30, 1973, does 42 U.S.C. §405(h) preclude district court review of a medicare regulation which exceeds the SECRETARY'S authority and contravenes express limitations in the enabling legislation?

Subsidiary to the primary question are the following issues:

(1) Whether §405(h) applies to providers in those situations wherein the Medicare Act makes no provision for judicial review?

(2) Whether §405(h) precludes the District Court from compelling the Secretary of Health, Education and Welfare to perform a non-discretionary duty under the Medicare Act through an action in the nature of Mandamus under 28 U.S.C. §1361?

(3) Whether Congress can constitutionally preclude judicial review of the validity of a medicare regulation even if the regulation contravenes the central purpose of the enabling legislation?

STATUTES AND REGULATIONS

This case arises under the Medicare Subchapter, 42 U.S.C.A. §1395 et seq. (1974), however, certain provisions of the Social Security Subchapter 42 U.S.C. §401 et seq., are involved because they are incorporated by reference into the Medicare Subchapter by 42 U.S.C.A. §1395ii (1974), which provides in pertinent part as follows:

> "The provisions of . . . subsection . . . (h) of Section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter."

The language of 42 U.S.C. §405(h) which is incorporated into the Medicare Subchapter as above described, reads as follows:

> "The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearings. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under Section 41 of Title 28 to recover on any claim arising under this subchapter."

The above quoted §405(h) refers to a portion of the former Judicial Code which at one time was codified at 28 U.S.C. §41 (1940). The provisions of former §41 of Title 28 are too lengthy to be repeated here and appear in the Appendix. Former §41 contained various jurisdictional grants including the equivalent of the current statute pertaining to federal question jurisdiction, 28 U.S.C. §1331. However, former §41 did not contain any grant of jurisdiction for actions in the nature of Mandamus. The Mandamus Statute, which is codified at 42 U.S.C. §1361, reads as follows:

> "The District Courts shall have original jurisdiction of any action in the nature of Mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the Plaintiff."

Also involved is 42 U.S.C. §405(g) which, according to the provisions of 42 U.S.C.A. §1395ff(b) (1974), provides review for individuals but not for providers. These provisions are set forth in the Appendix.

The medicare regulation which was challenged by the HOSPITAL is codified at 20 C.F.R. §405.486(b) (1) (1977). Because of its length, the text of the regulation is also set forth in the Appendix.

STATEMENT OF THE CASE

Although the question presented by this petition is the right to judicial review, it is important to summarize briefly the HOSPITAL'S claim on the merits. The nature of the HOSPITAL'S claim is particularly relevant to the availability of judicial review.

The HOSPITAL is a "Provider of Services" within the meaning of 42 U.S.C.A. §1395x(u) (1974) and "qualified to participate" under the medicare program pursuant to 42 U.S.C.A. §1395cc (1974). During its fiscal years 1967-72, the HOSPITAL leased a portion of its premises to a group of radiologists who conducted a practice in radiology on the leased premises. Besides furnishing space, the lease required the HOSPITAL to provide certain utilities and janitorial and related services. Billing for the radiology services was the responsibility of the physicians and was rendered in their name.

The HOSPITAL did not seek or receive reimbursement from the medicare program for any costs associated with the leased premises during the years in question. All of the direct costs associated with the leased facility, not paid by the radiologists themselves, were paid out of gross lease revenues during the years 1967 through 1972. Furthermore, the leased facilities' pro-rata share of indirect hospital costs was paid out of lease revenues and all such indirect costs were eliminated from the HOSPITAL'S cost reports submitted under the medicare program. In other words, *all* costs incurred by the HOSPITAL and associated with the radiology facility were paid out of lease revenues. The medicare program never paid the HOSPITAL one penny of the costs associated with the leased facility.

After paying the above-described costs out of lease revenues, the HOSPITAL was left with net income from the leasing of the radiology facility totalling $719,933.04. This dispute arises out of the fact that the SECRETARY, in computing the amount of reimbursement due the HOSPITAL under the medicare program, arbitrarily reduced the amount of otherwise reimbursable costs incurred in connection with *other* departments of the HOSPITAL by the amount of net income earned through the leasing of the radiology facility. The basis for this action was a regulation of the SECRETARY codified as 20 C.F.R. §405.486(b) (1) (1977).[1] The HOSPITAL challenged the use of the regulation to require a set-off. The HOSPITAL did *not* challenge the SECRETARY'S discretionary function of determining the amount of allowable and reasonable costs. Instead, the HOSPITAL argued that the SECRETARY could not disobey the congressional command to reimburse for

[1]The pertinent portion of the regulation is set forth below:

> "Where a hospital initially pays some or all of the operating expenses of a hospital department (e.g. pays the salaries of non-professional personnel and purchases supplies and equipment), even though subsequently those items and services for which it pays the operating expenses are furnished for the use of the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimburseable under the hospital insurance program as hospital costs, and are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program."
>
> 20 C.F.R. §405.486(b)(1)(1977)

costs which he had in fact determined to be allowable and reasonable.[2]

Hearings were held pursuant to 20 C.F.R. §405.492 (1974) and final administrative decisions against the HOSPITAL were entered by a provider appeals committee of the Blue Cross Association.[3] Upon exhausting the administrative review process, the HOSPITAL filed suit in the District Court for the Southern District of Florida challenging the validity of the regulation as interpreted by the SECRETARY. Upon the entry of final summary judgment in favor of the SECRETARY, an appeal was taken to the Court of Appeals for the Fifth Circuit.

In its first opinion, the Fifth Circuit found jurisdiction to review the case under Section 10 of the Administrative Procedure Act, 5 U.S.C. §§701-706. The opinion went on to find for the HOSPITAL on the merits holding that the regulation could not be applied "to a hospital which received no reimbursement under the Hospital Insurance Program for the operation of its radiology program." *Dr. John T. MacDonald Foundation, Inc. v. Mathews,* 534 F.2d 633, 639 (5th Cir. 1976).

While the SECRETARY'S petition for rehearing was pending, this Court decided that Section 10 of the APA was not an independent grant of subject matter jurisdiction. *Califano v. Sanders,* 430 U.S. 99, 51 L. Ed. 2d 192, 97 S. Ct. 980 (1977). The Fifth Circuit then wrote

[2]The provision of the Medicare Subchapter requiring the SECRETARY to reimburse providers for their reasonable costs is 42 U.S.C.A. §1395f(b) (1974). The term reasonable costs is defined at 42 U.S.C.A. §1395x(v) (1974).

[3]See Exhibits E and F.

a second opinion in this case which denied the SECRETARY'S petition for rehearing and held "that during the period before it provided adequate statutory review within the Medicare Act, and during that period only, Congress did not intend §405(h) to preclude federal question jurisdiction over such matters as this." *Dr. John T. MacDonald Foundation, Inc. v. Mathews,* 554 F.2d 714, 718 (5th Cir. 1977). The holding was consistent with a line of cases from the Court of Appeals for the Second Circuit personified by *Aquavella, Inc. v. Richardson,* 437 F.2d 397 (2d Cir. 1971) and *Kingsbrook Jewish Medical Center v. Richardson,* 486 F.2d 663 (2d Cir. 1973).

A second petition for rehearing was filed by the SECRETARY and the Fifth Circuit heard this case *en banc* after which a third and final opinion was issued. The third opinion held that §405(h) precluded all review by the District Court and strongly implied that §405(h) was intended to preclude review in all inferior federal courts, including the Court of Claims. *See MacDonald,* 571 F.2d at 332. However, the third opinion recognized that the Court of Claims has decided that it has jurisdiction to review the SECRETARY'S decisions, at least as to law and constitutional claims, despite §405(h). *Whitecliff, Inc. v. United States,* 536 F.2d 347 (Ct. Cl. 1976), *cert. denied,* 430 U.S. 969, 52 L.Ed. 2d 361, 97 S. Ct. 1652 (1977). Acknowledging that a Statute of Limitations problem might exist, and being persuaded that the interests of justice would be furthered by transfer, the Court of Appeals then ordered this case transferred to the Court of Claims. Although grateful for this gesture, the HOSPITAL finds little comfort in the transfer since some cases under the transfer statute, 28

U.S.C. §1406(c), have held that it cannot be invoked by a court which lacks subject matter jurisdiction.[4]

[4]*See* Atlantic Ship Rigging Co. v. McLellan, 288 F.2d 589 (2d Cir. 1961). The HOSPITAL of course contends that this action would not be time barred if now commenced in the Court of Claims.

REASONS FOR ALLOWING THE WRIT

I.

THE CIRCUIT COURT HAS DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT.

This Court has often recognized that questions concerning the jurisdiction of the district courts are important enough to warrant review by writ of certiorari.[5] Prior to this Court's decision in *Califano v. Sanders*, 430 U.S. 99, 51 L. Ed. 2d 192, 97 S. Ct. 980 (1977), there were reported at least 13 circuit level opinions[6] and 16 district

[5]*See, e.g.* Bruner v. United States, 343 U.S. 112, 96 L.Ed. 786, 72 S. Ct. 581 (1952)

[6]Adams Nursing Home of Williamstown, Inc. v. Mathews, 548 F.2d 1077 (1st Cir. 1977) (405(h) does not apply to due process claims); Faith Hospital Association v. Blue Cross Hospital Service, 537 F.2d 294 (8th Cir.), *cert. denied*, 429 U.S. 977, 50 L. Ed. 2d 584, 97 S. Ct. 484 (1976) (adopts St. Louis University holding, *infra*); Gallo v. Mathews, 538 F.2d 1148 (5th Cir. 1976) (no jurisdiction under 28 U.S.C. §1331 although APA affords independent basis of jurisdiction); Hazelwood Chronic & Convalescent Hospital, Inc. v. Weinberger, 543 F.2d 703 (9th Cir. 1976) (certiorari granted, judgment vacated and case remanded to 9th Cir. for reconsideration in light of Califano v. Sanders) 430 U.S. 952, 51 L. Ed. 2d 801, 97 S. Ct. 1595 (1977)); Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, 425 U.S. 935, 48 L. Ed. 2d 176, 965 S. Ct. 1665 (1976) (court assumes jurisdiction over attempt by SECRETARY to recoup sums from Hospital); Pleasantview Convalescent and Nursing Center, Inc. v. Weinberger, 565 F.2d 99 (7th Cir. 1976) (jurisdiction over provider reimbursement disputes under APA and 28 U.S.C. §1331); South Windsor Convalescent Home, Inc. v. Mathews, 541 F.2d 910 (2d

court opinions[7] which wrestled with the question of whether the district courts have jurisdiction to review pre-1973 provider reimbursement disputes. In the short

[6]—Continued

Cir. 1976) (*Salfi* bars jurisdiction over constitutional claim; Court of Claims would have jurisdiction); St. Louis University v. Blue Cross Hospital Service, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977, 50 L. Ed. 2d 584, 97 S. Ct. 484 (1976) (405(h) no bar to jurisdiction over constitutional claims where Medicare Act does not provide adequate alternative procedure for review); Rothman v. Hospital Service of Southern California, 510 F.2d 956 (9th Cir. 1975) (jurisdiction under APA if no alternative review procedures for compliance with constitutional and statutory provisions or arbitrary and capricious action); Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663 (2d Cir. 1973) (jurisdiction under APA); Aquavella v. Richardson, 437 F.2d 397 (2d Cir. 1971), (where Act does not provide review procedures, 405(h) does not preclude jurisdiction); Whitecliff, Inc. v. United States, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969, 52 L. Ed. 2d 361, 97 S. Ct. 1652 (1977) (Court of Claims has jurisdiction to determine compliance with statutory and constitutional provisions); Goldstein v. United States, 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 974, 38 L. Ed. 2d 217, 94 S. Ct. 287 (1973) (Court of Claims has jurisdiction only over constitutional claims or procedures violative of Social Security Act).

[7]American Ass'n of Councils of Medical Staffs v. Mathews, 421 F. Supp. 848 (E.D. La. 1976) (no jurisdiction under 28 U.S.C. §1331, but found jurisdiction under APA); Behlen Community Hospital v. Blue Cross of Nebraska, 419 F. Supp. 683 (D. Neb. 1976) (jurisdiction over pre-1973 claims relating to due process; no jurisdiction under 28 U.S.C. §1331 or APA to review reimbursement claims); Hillside Community Hospital of Ukiah v. Mathews, 423 F. Supp. 1168 (N.D. Cal. 1976) (jurisdiction based on APA); Hopewell Nursing Home, Inc. v. Mathews, CCH Medicare and Medicaid Guide ¶ 27,913 (1976 Transfer Binder) (D.S.C. 1976) (jurisdiction for review of guidelines under 28 U.S.C. §1331 or APA); Humana of South Carolina, Inc. v. Mathews, 419 F. Supp. 253 (D.D.C. 1976) (405(h) inapplicable where Medicare Act provides no procedure for judicial review; nonstatutory review available under 28 U.S.C.

time since this Court held in the *Sanders* case that Section 10 of the APA was not an independent grant of subject matter jurisdiction, 5 circuit level opinions[8] and 13

[7]—Continued

§1331); Lowry Hosptial Ass'n v. Blue Cross Blue Shield of Tennessee, 415 F. Supp. 589 (E.D. Tenn. 1976) (jurisdiction not discussed; SECRETARY has common law right to recoup overpayments made under medicare program); Saint Francis Memorial Hospital v. Weinberger, 413 F. Supp. 323 (N.D. Cal. 1976) (jurisdiction over pre-1973 claims under APA); Americana Nursing Centers, Inc. v. Weinberger, 387 F. Supp. 1116 (S.D. Ill. 1975) (would find jurisdiction if no other review procedure provided by Act); South Boston General Hospital v. Weinberger, 397 F. Supp. 360 (W.D. Va. 1975) (405(h) no bar to jurisdiction under APA where Social Security Act does not provide review of compliance with constitutional and statutory provisions); Columbia Heights Nursing Home and Hospital, Inc. v. Weinberger, 380 F. Supp. 1066 (M.D. La. 1974) (jurisdiction based on federal question and APA); Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger, 376 F. Supp. 1099 (S.D. Fla. 1974) (jurisdiction under APA) *rev'd*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, 425 U.S. 935, 48 L.Ed.2d 176, 96 S.Ct. 1665, (1976); Kingsbrook Jewish Medical Center v. Richardson, 355 F. Supp. 965 (E.D.N.Y. 1973) (no jurisdiction to review cost reimbursement dispute); Temple University v. Associated Hospital Service of Philadelphia, 361 F. Supp. 263 (E.D. Pa. 1973) (jurisdiction under APA); Coral Gables Convalescent Home, Inc. v. Richardson, 340 F. Supp 646 (S.D. Fla. 1972) (allows judicial review of due process challenge); Schroeder Nursing Care, Inc. v. Mutual of Omaha Insurance Company, 311 F. Supp. 405 (E.D. Wisc. 1970) (no jurisdiction over determinations of reasonable costs); Aquavella v. Finch, 306 F. Supp. 860 (W.D.N.Y. 1969) (no jurisdiction).

[8]Association of American Medical Colleges v. Califano, 569 F.2d 101 (D.C. Cir. 1977) (no jurisdiction since administrative remedies not exhausted); Trinity Memorial of Cudahy, Inc. 570 F.2d 660 (7th Cir. 1977) (suggests district court has jurisdiction over procedural due process claims); Appalachian Regional Hospitals, Inc. v. United States, 3 CCH Medicare and Medicaid Guide ¶ 29,026 (Ct. Cl. 1978) (assumes jurisdiction over pre-1973 claims); Gosman v. United States, 573 F.2d 31 (Ct. Cl. 1978) (Court of

district court opinions[9] dealing with this specific question were reported. Indeed, as recently as July 1977, the SECRETARY in his second petition for rehearing before

[8]—Continued

Claims has jurisdiction over pre-1973 cost reporting periods); Overlook Nursing Home, Inc. v. United States, 556 F.2d 500 (Ct. Cl. 1977) (Court of Claims has jurisdiction to review pre-1973 reimbursement claims); St. Elizabeth Hospital v. United States, 558 F.2d 8 (Ct. Cl. 1977) (Court has jurisdiction to review pre-1973 reimbursement claims).

[9]Clark County Memorial Hospital and Nursing Home v. Califano, 3 CCH Medicare and Medicaid Guide ¶ 28,891 (E.D. Ark. 1978) (jurisdiction over constitutional claims); Eugene & Schupak v. Califano, 3 CCH Medicare and Medicaid Guide ¶ 28,955 (E.D. N.Y. 1978) (jurisdiction over constitutional claims under 28 U.S.C. §1331); Memorial, Inc. v. Califano, 3 CCH Medicare and Medicaid Guide ¶ 28,932 (C.D. Cal. 1978) (no jurisdiction over pre-1973 provider reimbursement claims); Mercy Hospital and Medical Center San Diego v. Califano, 3 CCH Medicare and Medicaid Guide ¶ 28,840 (S.D. Cal. 1978) (no jurisdiction over pre-1973 provider claims); Unihealth Services Corp. v. Califano, 448 F. Supp. 1059 (E.D. La 1978) (jurisdiction over due process claims under 28 U.S.C. §1331); Chelsea Community Hospital v. Michigan Blue Cross, 436 F. Supp 1050 (E.D. Mich. 1977) (Court has no jurisdiction to review even constitutional claims related to pre-1973 reimbursement claims, but assumes jurisdiction *arguendo* since constitutional claims are without merit); Daytona Beach General Hospital, Inc. v. Weinberger, 435 F. Supp. 891 (M.D. Fla. 1977) (district court has jurisdiction to review constitutional challenge, but neither district court nor Court of Claims has jurisdiction over amount of recoupment); James D., Inc. v. Nationwide Insurance Co., (S.D. Ohio 1977) CCH Medicare and Medicaid Guide ¶ 28,402 (1977 Transfer Binder) (no jurisdiction to review pre-1973 provider reimbursement disputes alleging deprivation of due process under APA or federal question statute); Medical Center of Independence v. Califano, 433 F. Supp. 837 (W.D. Mo. 1977) (even if plaintiff had exhausted administrative remedies, court lacks jurisdiction to review merits of pre-1973 claims); Pacemaker Monitor Corp. v. United States Government,

the Court of Appeals characterized the question as one "of importance with respect to federal court jurisdiction" affecting approximately 27 medicare reimbursement cases pending before the Fifth Circuit or district courts within that circuit, "involving approximately $10 million in medicare funds."[10] It seems a fair assumption that the nationwide litigation on this question is at least ten-fold that of the Fifth Circuit.

In the interest of judicial economy, this question should be resolved. Given the fact that several of the circuit courts have not addressed this question, there is likely to be much more time-consuming litigation on this narrow but important question of federal jurisdiction. Furthermore, the Court of Claims, which has decided that it has jurisdiction to review pre-1973 provider reimbursement disputes,[11] will undoubtedly expend countless judicial time developing expertise and a body of case law in the complex medicare field only to

[9]—Continued

440 F. Supp. 473 (S.D. Fla. 1977) (jurisdiction to hear constitutional claims); Pacific Coast Medical Enterprises v. Califano, 440 F. Supp 296 (C.D. Cal. 1977) (no jurisdiction over pre-1973 claims); St. Elizabeth Hospital v. Califano, 441 F. Supp 158 (E.D. Ky. 1977) (no jurisdiction to review reasonable cost decisions prior to 1973; transfer to Court of Claims); Trustees of Indiana University (Indiana University Hospitals) v. Blue Cross Ass'n, 445 F. Supp. 617 (S.D. Ind. 1977) (no jurisdiction over pre-1973 claims even if constitutional challenge).

[10]The cases referred to by the SECRETARY were listed in an Addendum to his second petition for rehearing. A copy of that Addendum is appended hereto as Exhibit G.

[11]See Whitecliff, Inc. v. United States, 536 F.2d 347 (Ct. Cl. 1976) *cert. denied*, 430 U.S. 969, 52 L.Ed. 2d 361, 97 S. Ct. 1652 (1977).

find that the medicare cases in the Court of Claims disappear after a few years because Congress has specifically granted the district courts' jurisdiction to review post-1973 disputes.[12] Clearly intervention by the Supreme Court is required in order to avoid the needless expenditure of precious judicial labor.

II.

THE DECISION IS IN CONFLICT WITH THE DECISIONS OF OTHER COURTS OF APPEALS

Since this Court decided the cases of *Weinberger v. Salfi*, 422 U.S. 749, 45 L. Ed. 2d 522, 95 S. Ct. 2457 (1975) and *Califano v. Sanders*, 430 U.S. 99, 51 L. Ed. 2d 192, 97 S. Ct. 980 (1977), a hopeless disarray of conflicting decisions has arisen on the question of whether §405(h) precludes judicial review in the district courts. The instant case flatly holds that §405(h) precludes *all* review in the district courts. On the other hand, the Second and Ninth Circuits have clearly held that §405(h) does not preclude the district courts from exercising their Mandamus jurisdiction under 28 U.S.C. §1361. See *Frost v. Weinberger*, 515 F.2d 57 (2d Cir. 1975), *cert. denied*, 424 U.S. 958, 47 L. Ed. 2d 364, 96 S. Ct. 1435 (1976); *White v. Mathews*, 559 F.2d 852 (2d Cir. 1977), *cert. denied*, Case No. 77-866 47 U.S.L.W. 3541 (1978); *Elliott v. Weinberger*, 564 F.2d 1219 (9th Cir. 1977), *cert. filed*, Case No. 77-1511 (Mar. 21, 1978).[13] The HOSPITAL argued in its brief before the Fifth Circuit that jurisdiction was available under §1361 because the challenged regulation contravened a non-discretionary duty under the Medicare Act.[14] But the Fifth Circuit found §405(h) to preclude all district court jurisdiction. A plain conflict with *Frost*, *White*, and *Elliott*, *supra*.

Other conflicts also exist. In *St. Louis University v. Blue Cross Hospital Service, Inc.*, 537 F.2d 283 (8th Cir. 1976), *cert. denied*, 429 U.S. 977, 50 L. Ed. 2d 584, 97 S. Ct. 484 (1976), the Eighth Circuit held that §405(h) did

[12]42 U.S.C.A. §1395oo(f) (Supp. 1978), *as amended*, Pub. L. 93-484, §3(a), 88 Stat. 1459 (Oct. 26, 1974).

[13]By way of dicta, the Seventh Circuit implied that district courts would be empowered to grant Mandamus relief despite §405(h), at least as to procedural due process issues, *See* Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc., 570 F.2d 660, at fn. 9 (7th Cir. 1977). The District of Columbia Circuit also implied that the district courts would have jurisdiction to review pre-1973 medicare disputes by way of Mandamus. *See* Association of American Medical Colleges v. Califano, 569 F.2d 101 (D.C. Cir. 1977).

[14]The SECRETARY argued that the HOSPITAL did not expressly plead 28 U.S.C. §1361 in its Complaint. This argument ignores the notice pleading doctrine.

> "If facts giving the court jurisdiction are set forth in the Complaint, the provision conferring jurisdiction need not be specifically pleaded."
>
> *Williams v. United States*, 405 F.2d 951, 954 (9th Cir. 1969), *citing Schwarz v. United States*, 191 F.2d 618 (4th Cir. 1951).

Furthermore, 28 U.S.C. §1653 provides that "[d]efective allegations of jurisdiction may be amended, upon terms, in the trial or appellate courts." *See*, Jones v. Freeman, 400 F.2d 383 (8th Cir. 1968).

not preclude district court review of a provider procedural due process claim. The Seventh Circuit, in *Trinity Memorial Hospital of Cudahy, Inc v. Associated Hospital Service Inc.*, 570 F.2d 660 (7th Cir. 1977), held that §405(h) precluded all district court review but that the Court of Claims could review as to procedural due process issues only and not on the merits.

The various conflicting decisions are primarily the product of a misreading of this Court's decision in the case of *Weinberger v. Salfi, supra.* It is the misinterpretation of *Salfi* that has caused the Fifth Circuit and other federal courts to decide an important question pertaining to the reviewability of administrative action in a manner directly contrary to long-standing principles established by this court.

III.

THE DECISION IS WRONG AND CONFLICTS WITH LONG-STANDING PRINCIPLES ESTABLISHED BY THIS COURT REGARDING THE REVIEWABILITY OF ADMINISTRATIVE ACTION.

Administrative action is subject to a strong presumption of reviewability.

> "[J]udicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress."
>
> *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140, 18 L.Ed. 2d 681, 686, 87 S.Ct. 1507 (1967).

There is no clear and convincing evidence that §405(h) was intended to apply to providers. The section refers only to "individuals." Under the Medicare Subchapter, individuals were given the right to judicial review under §405(g) of the Social Security Subchapter. See 42 U.S.C.A. §1395ff(b) (1974). It was only natural that Congress would incorporate the companion §405(h) into the Medicare Subchapter for the purpose of limiting and confining *individuals* to the review provided in §405(g).

Many of those courts which have divined an intent on the part of Congress to preclude judicial review for pre-1973 provider disputes have done so on the basis of the 1974 amendment which specifically provided for judicial review for accounting periods after June 30, 1973.[15] But the amendment providing for judicial review after 1973 confirms that Congress did not intend to preclude review in the earlier years. When Congress amends particular legislation, it is presumed to be "aware of the settled judicial construction" given to the statutory language. *Shapiro v. United States*, 335 U.S. 1, 16, 92 L. Ed. 1787, 68 S. Ct. 1375 (1948).

> "In searching for the will and intent, it is to be assumed that Congress was aware of established rules of law applicable to the subject matter of the statute, and thus, upon enactment, the statute is to be read in conjunction with the entire existing body of law."
>
> *Kansas City, Missouri v. Federal Pacific Electric Co.*, 310 F.2d 271, 275 (8th Cir. 1962).

[15]See 42 U.S.C.A. §1395oo(f) (Supp. 1978), *as amended by*, Pub. L. 93-484 Section 3(b), 88 Stat. 1459 (October 26, 1974).

It must be presumed that Congress, when it created the Provider Reimbursement Review Board and provided for judicial review of post-1973 decisions was well aware of the trend among the federal courts to apply §405(h) only with respect to those cases specifically reviewable under §405(g). At that time there were no less than seven decisions holding that non-statutory review was available for those provider reimbursements disputes not reviewable under a specific provision of the Medicare Subchapter, despite the language of §405(h).[16] If Congress wanted to prevent this result, it could simply have included in the amendment a specific statement precluding the review of pre-1973 provider disputes. But instead Congress was silent as to accounting periods prior to June 30, 1973, thus implying consent to or acquiescence in the construction given §405(h) by

[16]Aquavella v. Richardson, 437 F.2d 397 (2d Cir. 1971) (405(h) does not preclude federal court review where the statute does not provide for other means of review); *accord*, Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663 (2d Cir. 1973); Coral Gables Convalescent Home v. Richardson, 340 F. Supp. 646 (S.D. Fla. 1971); Temple University v. Associated Hospital Service of Philadelphia, 361 F. Supp. 263 (E.D. Pa. 1973); Mt. Sinai Hospital of Greater Miami v. Weinberger, 376 F. Supp. 1099 (S.D. Fla. 1974); Columbia Heights Nursing Home v. Weinberger, 380 F. Supp. 1066 (M.D. La. 1974). See also Goldstein v. United States, 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 974, 38 L. Ed. 2d 217, 94 S. Ct. 287 (1973) (405(h) does not preclude jurisdiction under the Tucker Act, 28 U.S.C. §1491, in the Court of Claims to determine if the SECRETARY'S decision violates the Constitution or governing statute); Schroeder Nursing Care, Inc. v. Mutual of Omaha, 311 F. Supp. 405 (E.D. Wisc. 1970) (No jurisdiction to determine reasonableness of reimbursement cost determination, but Court did consider claims that the SECRETARY, in determining provider's reimbursement, relied upon guidelines which were in violation of the governing statute and Constitution).

Aquavella and similar cases. Indeed, the Conference Report for Public Law 93-484 reads as follows:

> "The amendment will specifically not apply to *other judicial review avenues* existing with respect to cost reports for periods prior to June 30, 1973."
>
> Conference Report No. 93-1407, 1974, U.S. Code Cong. Admin. News 5995, 5996 (emphasis added).

Clearly, Congress knew that the courts were allowing providers to sue and did not affirmatively act to prevent non-statutory review. The logical reading of the history of the Medicare Subchapter is that Congress decided to accept the non-statutory review fashioned by the courts for provider accounting periods up to June 30, 1973 and imposed one of its own making for the years thereafter. To interpret the addition of a specific review provision for post-1973 accounting periods as precluding review for the period prior thereto would be to violate the principle announced by this court in *Abbott Laboratories v. Gardner, supra.*

> " 'The mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to review is too important to be excluded on such slender and indeterminate evidence of legislative intent.' "
>
> *Abbott Laboratories v. Gardner, supra* 387 U.S. at 141, 18

> L. Ed. 2d at 687, *quoting from*, Jaffe, Judicial Control of Administrative Action, at 357 (1965).

More is at issue here than the intent of Congress regarding the availability of judicial review. The right of Congress to preclude review even of agency action prohibited by the enabling legislation is also presented. If the Fifth Circuit is right in its contention that the *Salfi* case has silently overruled the long line of decisions holding that §405(h) does not preclude non-statutory review if it is otherwise unavailable,[17] then the Court of Claims to which this case had been transferred may have no jurisdiction because the Court of Claims has based its acceptance of pre-1973 provider disputes on those very same cases. See *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct. Cl. 1976). If the Fifth Circuit is right, then there is no jurisdiction in any court to review this case. This was the position taken by Judge James C. Hill in his dissent from the portion of the opinion ordering transfer to the Court of Claims.

But §405(h) should not be and cannot be interpreted so as to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like BCA. "Such a result would be

[17]*See*, e.g., Aquavella v. Richardson, 437 F.2d 397 (2d Cir. 1971); Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663 (2d Cir. 1973); Rothman v. Hospital Serv., 510 F.2d 956 (9th Cir. 1975); Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co., 311 F. Supp. 405 (E.D. Wisc. 1970); South Boston Gen. Hosp. v. Weinberger, 397 F. Supp. 360 (W.D. Va. 1975).

of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review." *Whitecliff, supra* at 350.

The regulation as applied to this case was found by the Fifth Circuit to be "arbitrary and capricious" and "not otherwise in accordance with the law." *MacDonald*, 534 F.2d at 639. The regulation as applied violates the central purpose of the Act. It is an effort by the SECRETARY to control provider income which is strictly forbidden by the Act.[18] Agency action so contrary to the purpose of the enabling legislation is always reviewable.

> "Reviewing courts are not obliged to stand aside and rubber stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate congressional policy underlying a statute. Such review is *always* properly within the judicial province and courts would abdicate their responsibility if they did not fully review such administrative decisions."
>
> *NLRB v. Brown*, 380 U.S. 278, 292, 13 L. Ed. 2d 839, 849, 85 S.

[18]It is not possible in this petition to go into any detail on the HOSPITAL'S argument on the merits. It must suffice to say that the regulation contravenes 42 U.S.C.A. §1395 (1974) as well as 42 U.S.C.A. §1395x(v)(1)(A) (1974) to the extent that it deprives reimbursement for costs determined by the SECRETARY to be reasonable and thereby insures that the cost of delivering covered services to covered individuals will be borne by those individuals not so covered in direct violation of the Act.

Ct. 980 (1965) (emphasis added). *See also, Harmon v. Bruker,* 355 U.S. 579, 2 L. Ed. 2d 503, 78 S. Ct. 433 (1958).

If Congress, through §405(h), has precluded even such minimal review as is necessary to determine that the SECRETARY has complied with the central purpose of the Medicare Act, the preclusionary provision must fail for it deprives the Act of all meaningful standards. *Cf. Schechter Corporation v. United States,* 295 U.S. 495, 79 L. Ed. 1570, 55 S. Ct. 837 (1935), *followed in, National Cable Television Association v. United States,* 415 U.S. 336, 39 L. Ed. 2d 370, 94 S. Ct. 1146 (1974).

It is respectfully submitted that review by this Court is necessary to correct the decision of the Court of Appeals and to settle an important question of federal law.

CONCLUSION

WHEREFORE, Petitioner, the DR. JOHN T. MACDONALD FOUNDATION, INC., respectfully prays that a writ of certiorari issue to review the *en banc* judgment of the United States Court of Appeals for the Fifth Circuit entered in this proceeding on April 17, 1978.

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Appendix

EXHIBIT A

DR. JOHN T. MacDONALD FOUNDATION, INC., d/b/a Doctors' Hospital, a Florida Corporation not for profit, Plaintiff-Appellant,

v.

Joseph A. CALIFANO, Jr., Secretary of Health, Education and Welfare, Blue Cross Association, an Illinois Corporation and Blue Cross of Florida, Inc., a Florida Corporation, Defendants-Appellees.

No. 75-2966.

United States Court of Appeals,
Fifth Circuit.

April 17, 1978.

Appeal from the United States District
Court for the Southern District of Florida.

Before BROWN, Chief Judge, and COLEMAN, GOLDBERG, AINSWORTH, GODBOLD, DYER, MORGAN, CLARK, RONEY, GEE, TJOFLAT, HILL, FAY, RUBIN, and VANCE, Circuit Judges.

LEWIS R. MORGAN, Circuit Judge:

In this action the appellant appeals the grant of summary judgment in favor of appellees. The issue, *en banc*, is whether jurisdiction exists in the federal district court to review decisions of the Secretary of HEW awarding reimbursement under the Medicare Act, 42

U.S.C. §1395 *et seq.* In its two previous appellate appearances, the panel had held that the district court had review jurisdiction and had reversed the summary judgment. Because we hold that Congress precluded the review of the Secretary's decision, we vacate the panel's decision, dismiss, and transfer.

The appellant Foundation is a hospital acting as a "provider of services" as defined in the Medicare Act, 42 U.S.C. §1395ii. As provided by the Medicare Act, providers are reimbursed through a fiscal intermediary for costs incurred in treating Medicare recipients. In the instant case, the dispute centers on whether income reduces reimbursable cost. From 1967 until 1972, the hospital leased a portion of its premises to a group of radiology physicians. The members of the group were the sole obligors of the lease obligation. During the vitality of the lease, all direct costs of the leasehold and the leasehold's pro rata share of indirect costs of the hospital were allocated to the gross rental income. In its reports to the Secretary, the hospital excluded all costs allocated to the leased operations and also excluded the net income realized. The Secretary took the position that the lease could not be segregated and reduced the hospital's reimbursement of costs under the Medicare Act by the amount of the net rental income received from the lease. Appellants contend that the Secretary misinterpreted the regulation[1] governing this situation, that the Secretary lacked authority to promulgate the regulation if the Secretary's interpretation is upheld, and, pressed for the first time on appeal, that the Secretary's action in reducing reimbursement costs constituted an unconstitutional denial of substantive due

[1]20 C.F.R. §405.486(b)(1) (1974).

process.[2] After exhausting their administrative remedies, appellants brought suit below and the court granted appellee's petition for summary judgment on the merits. The substantive issue for the instant litigation is the correctness of the Secretary's method for determining cost. The issue considered by this court, on appeal, however, is whether the district court had jurisdiction to review the Secretary's determination.

The question can be framed quite simply: Does 42 U.S.C. §405(h), incorporated by reference into the Medicare Act by 42 U.S.C. §1395ii, preclude district court review of a decision by the Secretary? To answer this question the statutory methodology of the Medicare Act must be briefly examined. When Congress created the Medicare Act, it selected and incorporated by reference the preclusion of review section of the Social Security Act, §405(h), in its entirety. Section 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States,

[2]Of course we do not address this issue in the course of this appeal and could not. *See Shelley v. Kraemer*, 334 U.S. 1, 68 S.Ct. 836, 92 L.Ed. 1161 (1947). We do, however, recognize that leave to amend their complaint to reflect their constitutional claim could be granted. Because the existence of a constitutional claim is pertinent to the question of preclusion of review, we will analyze the preclusion of review issue recognizing tyat appellant does have a claim of constitutional magnitude.

> the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

Because §1331 was previously codified as a subsection of §41 of Title 28, §405(h) purports to preclude review under federal question jurisdiction. Congress did not, however, incorporate §405(g) which provides the review machinery referred to in 405(h) "as herein provided." Because we normally presume the review power to exist in inferior federal courts, the question becomes whether Congress intended by this combination of expression and omission, to preclude review.

In the two previous panel opinions, the court held that review jurisdiction existed in the district court. Although the result was the same, the paths taken were different. In the first decision, reported at 534 F.2d 633 (1976), the court held that §10 of the A.P.A. provided the district court with jurisdiction to review agency decisions. The court based its holding on the doctrine that if review procedures are statutorily provided they are exclusive, but if no mechanism is provided then non-statutory methods are available. The Supreme Court quickly disabused us of that notion, however, in *Califano v. Sanders*, 430 U.S. 99, 97 S. Ct. 980, 51 L.Ed.2d 192 (1977), holding that §10 does not provide an independent source of subject matter jurisdiction to review agency actions. The Court based its holding on the recent expansion of §1331(a) jurisdiction that obliterated any necessity for §10 review jurisdiction and therefore evidenced Congress' intent that §10 was not an independent source of jurisdiction. *Sanders* necessitated the second panel attempt, reported at 554 F.2d 714

(1977). The court again held that review jurisdiction existed, not under the A.P.A., but pursuant to 28 U.S.C. §1331, the basic grant of federal question jurisdiction. Although the court held that §1331 provided jurisdiction, the court limited the availability of such review to the "time window" from 1968 until the Congress expressly provided review machinery in 1973.[3] Again the Supreme Court has provided us with assistance, however. In *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), the Court held that §405(h) precludes district court review of Social Security Act awards. The Court held not only that §1331 review of the merits of the award was unavailable, but also that constitutional claims were precluded. Hence, this *en banc* determination.

The evolution of this issue in our court is reflected in the varied treatments of the same issue in the other forums. The Eighth Circuit has held that although §405(h) precludes review of agency findings of fact and law, §405(h) does not preclude jurisdiction to entertain constitutional claims. *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir. 1976), *cert. denied*, 429 U.S. 977, 97 S.Ct. 484, 50 L.Ed.2d 584 (1977). The Second and Seventh Circuits have determined that §405(h) precludes district court review of all claims arising under the Medicare Act, including constitutional claims. They did "hold," however, that review jurisdiction exists in the Court of Claims.[4] *South*

[3] In 1973, Congress established the Provider Reimbursement Review Board to resolve controversies between providers and intermediaries. The amendment creating the Board is effective only for accounting periods ending on or after June 30, 1973. 42 U.S.C. §1395oo (Supp. III 1970).

[4] Can they do this? See n.7 *infra* and accompanying text.

Windsor Convalescent Home, Inc. v. Mathews, 541 F.2d 910 (2d Cir. 1976); *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir., decided Dec. 16, 1977). To complete the spectrum, the Court of Claims has held that jurisdiction exists in the Court of Claims pursuant to 28 U.S.C. §1491 to review the Secretary's decision, at least as to law and constitutional claims, despite §405(h). *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct.Cl.1976), *cert. denied*, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977).

These decisions were necessitated by and based upon the Supreme Court decision in *Weinberger v. Salfi, supra.* In *Salfi*, although the Court did not analyze §405(h) in the Medicare context, the Court did hold that §405(h) precludes district court review of claims arising under the Social Security Act, from which §405(h) was lifted. Plaintiffs brought a class action, styled under §1331, claiming the statute denying benefits to widows married less than nine months to the deceased wage earner to be unconstitutional. Although the claim in *Salfi* was styled under the Constitution, the Court held that because the Social Security Act provided both the remedy and the right, the claim, even though the constitutional magnitude, arose under the Social Security Act. The Court concluded that because §405(h), on its face, precluded §1331 review of any "action," the language included not only preclusion of review on the merits of the award but also of constitutional claims.

[1] Of course, because the instant litigation arose under the Medicare Act, *Salfi* is not binding on us. We are not convinced, however, that factors sufficiently distinguishing the instant case from the *Salfi* situation ex-

ist to warrant a different result.[5] In *Salfi*, the Court made it abundantly clear that the presence of a constitution claim will not overcome the statutory preclusion of review and that neither the merits nor the constitutional claim will be reviewed. Additionally, the legislative history of both §405(h) and §1395ii of the Medicare Act support this view. As discussed *supra*, although Congress expressly incorporated §405(h) by reference, they failed to incorporate §405(g) which provides the administrative and judicial review procedures for the Social Security Act. Assuming that when Congress incorporates sections specifically they intend to eschew the remainder, the conclusion is inescapable that §405(h) was intended to preclude all review. We therefore hold that §405(h), incorporated into §1395ii of the Medicare Act, precludes all review of the Secretary's decisions by federal district courts brought under §1331.

Because we hold that §405(h) precludes review of appellant's claim in district court, we are forced to address appellant's claim that §405(h) unconstitutionally denies due process to claimants precluded from seeking review of constitutional claims. This claim was not faced by the Supreme Court in *Salfi* because §405(g) existed to provide review of constitutional claims arising under the Social Security Act. Because §405(g) was not incorporated into the Medicare Act, its machinery is not available to review constitutional claims. Appellant bases this constitutional claim on *Califano v. Sanders*,

[5]The major factor distinguishing the two situations is the absence of §405(g) in the Medicare Act machinery. Because jurisdiction exists in the Court of Claims, the importance of the absence of §405(g) is mitigated.

supra, in which the Supreme Court held that §10 of the A.P.A. was not an independent grant of jurisdiction. In dictum, the Court recognized that a statute precluding all review of constitutional claims would raise a serious constitutional question of the validity of the statute.[6] *See also Weinberger v. Salfi*, 422 U.S. at 762, 95 S.Ct. 2457; *Johnson v. Robison*, 415 U.S. 361, 366-67, 94 S.Ct. 1160, 39 L.Ed.2d 389 (1974). Additionally, as the court stated in *Sanders*, because the availability of judicial review over constitutional claims is presumed, the presumption would be rebutted only by "clear and convincing" evidence of Congress' intent. 430 U.S. at 109, 97 S.Ct. 980; *Johnson v. Robison*, 415 U.S. at 366-67, 94 S.Ct. 1160.

[2] Happily, we need resolve neither Congress' intent to preclude review of constitutional claims nor the constitutionality of a statute so construed. We would face these issues only if *all* avenues of review were precluded. In *Whitecliff*, however, the Court of Claims determined it to have jurisdiction to review claims arising under the Medicare Act. This is a holding that we are powerless to overturn. The Court of Claims is an Article III court empowered to entertain constitution claims. 28 U.S.C. §1491. *See Miles v. Graham*, 268 U.S. 501, 45 S.Ct. 601, 69 L.Ed. 1067 (1925). Moreover, we have no review authority over the Court of Claims. 28 U.S.C. §1255, 28 U.S.C. §1291. Therefore, we have no authority to overturn the Court of Claims' determination of the scope of its own jurisdiction. Although we could hold that Congress intended §405(h) to preclude review in all inferior federal courts, including the Court

[6]At least as far as Supreme Court review, it would seem this question would be answered by *Marbury v. Madison*, 5 U.S. 137 (1 Cranch 137, 1803), 2 L.Ed. 60.

of Claims, such a holding would not be binding on the Court of Claims.[7] *Heaven Hill Distilleries, Inc. v. United States*, 476 F.2d 1327, 1335, 201 Ct.Cl. 423 (1973). Thus, as a matter of fact, all review is not precluded and therefore the constitutionality of §405(h) is not drawn into question.

[3, 4] Our finding that all review is not precluded would be cold comfort to appellant if, as a practical matter, another forum were unavailable because of a statute of limitations. Therefore, we transfer this case to the Court of Claims, pursuant to 28 U.S.C. §1406(c). Although this statute purports to limit the transfer power to the district court, we are convinced that Congress did not intend to prevent transfer directly from the appellate court. Direct transfer not only furthers the policies behind §1406, but also comports with the precepts of judicial economy.[8] Because we are persuaded that the interests of justice are furthered by transfer, we so order.

Dismissed and transferred.

RONEY, Circuit Judge, dissenting:

I respectfully dissent for the reasons stated in the panel opinion. *Dr. John T. MacDonald Foundation, Inc. v. Mathews*, 554 F.2d 714 (5th Cir. 1977). The *en banc*

[7]Because the Court of Claims is free to disregard a holding circumscribing their jurisdiction, any such determination would be an exercise in futility.

[8]*See Panhandle Eastern Pipe Line Co. v. Federal Power Commission*, 343 F.2d 905 (8th Cir. 1965); *Panhandle Eastern Pipe Line Co. v. Federal Power Commission*, 337 F.2d 249 (10th Cir. 1964).

court having decided the district court lacks jurisdiction, however, I would concur in the transfer of the case to the Court of Claims, which has decided it does have review jurisdiction in such cases. *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct.Cl.1976), *cert. denied*, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977). The check-and-balance theory that validates our system of government mandates against non-reviewable executive decisions.

GEE, Circuit Judge, with whom DYER, Circuit Judge, joins dissenting:

This seems to me a very close and difficult case. However, despite the well-reasoned majority opinion and the tolerable result that it reaches, I would adhere to the panel's disposition. *Dr. John T. MacDonald Foundation v. Mathews*, 554 F.2d 714 (1977). I therefore respectfully dissent.

JAMES C. HILL, Circuit Judge, concurring in part and dissenting in part:

I agree with the majority's holding that §405(h) precludes district court review of the appellant's claim. I disagree most heartily, however, with the majority's transfer of this cause of action to the Court of Claims. The majority's own analysis proves that the Court of Claims has no jurisdiction to review the appellant's claim. The language of §405(h) clearly shows the congressional intent to preclude all courts from reviewing claims such as the appellant's:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any . . . tribunal . . . except as herein provided. (emphasis supplied)

In *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), the Supreme Court interpreted this language as precluding all review of the Secretary's decisions except as provided in §405(g). 422 U.S. at 757, 95 S.Ct. 2457. Section 405(g) provides for neither district court nor Court of Claims review. Any doubt that could possibly remain as to Congress' intent is resolved by the legislative history of the Medicare Act.

The majority states that we are bound by the Court of Claims' determination that it has jurisdiction to review the Secretary's decision despite §405(h). This Court is no more bound by decisions of the Court of Claims than the Court of Claims is bound by this Court's decisions. See *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir. decided Dec. 16, 1977); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910, 914 (2d Cir. 1976); *United States v. Northside Realty Associates, Inc.*, 518 F.2d 884, 886 (5th Cir. 1975), *cert. denied*, 424 U.S. 977, 96 S.Ct. 1483, 47 L.Ed.2d 747 (1976); *United States v. Diamond*, 430 F.2d 688, 691-92 (5th Cir. 1970). *See also Thornton v. Toyota Motor Sales, U.S.A. Inc.*, 397 F.Supp. 476, 477 (N.D.Ga. 1975); *Johnson v. Helicopter & Airplane Services Corp.*, 389 F.Supp. 509, 522-25 (D.Md. 1974).

It seems to me that this issue comes down, in the final analysis, to a simple proposition. If we accept the Court of Claims' analysis of review jurisdiction, then we

must find that the district court has similar jurisdiction. Our correct conclusion, though, is that review is precluded. We thus respectfully disagree with that distinguished Court. We conclude that under the law enacted by the Congress, neither it nor this Court has jurisdiction. It is not judicial business to wish so earnestly that the appellant had a judicial forum that we send his case to a court which erroneously concludes that it can provide one.

Therefore, I must respectfully dissent from the majority's transfer of this cause to the Court of Claims.

EXHIBIT B

DR. JOHN T. MacDONALD FOUNDATION, INC., d/b/a Doctors' Hospital, etc.,
Plaintiff-Appellant,

v.

F. David MATHEWS, Secretary of Health, Education and Welfare, et al.,
Defendants-Appellees.

No. 75-2966.

United States Court of Appeals,
Fifth Circuit.

June 23, 1977.

Appeal from the United States District Court for the Southern District of Florida.

ON PETITION FOR REHEARING

Before DYER, CLARK and GEE, Circuit Judges.

GEE, Circuit Judge:

In our opinion herein, 534 F.2d 633 (5th Cir. 1976), we concluded that the district court was granted jurisdiction of this case by Section 10 of the Administrative Procedure Act. We have withheld action on motion for rehearing pending decision by the Supreme Court of *Califano v. Sanders*, ____U.S.____, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977). In it the Court has now

decided that the APA does not constitute an implied grant of subject-matter jurisdiction permitting federal judicial review of agency action. Thus, our original opinion erred as to this supposed head of jurisdiction. In consequence, we must now decide whether, despite *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), general federal-question jurisdiction obtains here — an issue which we expressly reserved in our earlier opinion.[1] The question is close. Sustained, however, in no small measure by the reflection that the issue is both discrete and so purely legal as to permit of a summary reversal without extensive factual research if we have miscarried, we find jurisdiction exists and deny rehearing.

Beyond peradventure, the Court's decision in *Sanders, supra,* has overruled the Social Security Act cases in our circuit on which we relied in our opinion herein.[2] And as *Lejeune v. Matthews* notes, *Salfi v. Weinberger* uprooted general federal-question jurisdiction in such Social Security cases.[3] None of these authorities, however, ours or the Court's, disposes of the question we now confront in this Medicare case.

For when the Congress confected the Medicare Act review provisions, it picked up the Social Security Act review-preclusion provision, 42 U.S.C. §405 (h), and incorporated it therein, complete with its reference to statutory judicial review "as herein provided." It omitted, however, to incorporate 42 U.S.C. §405(g), the section which "[t]herein provided" statutory review.[4] Did Congress, by the omission of this provision for statutory review — though maintaining the original reference to it in the preclusion statute — intend that during the time-window from 1968 to 1973 there should be no review of such Medicare matters as this? The words of §405(h) are "sweeping and direct";[5] it cannot be gainsaid that read literally they preclude *all* review. None is to be had except "as herein provided," and no review is herein provided for the Secretary's refusal to reopen and recompute the amount of reimbursement to this

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[1]We do not here decide if jurisdiction under §1331 survives *Salfi*. In *Ortego*, the court rejected §1331 jurisdiction not because of *Salfi* but because the jurisdictional amount was not met. However, a footnote in *Lejeune*, discussing *Salfi*, intimates that §1331 "is expressly negated as a possible source of jurisdiction by the third sentence of §405(h)." *Lejeune v. Matthews, supra* at 953 n.2. This may be true, but we note that in *Salfi* review was sought under §1331 for an order that was reviewable under §405(g), and this holding does not necessarily bar an action under §1331 in a provider reimbursement dispute that is not otherwise reviewable.

534 F.2d at 636 n.6.

[2]*Ortego v. Weinberger*, 516 F.2d 1005 (5th Cir. 1975); *Lejeune v. Matthews*, 526 F.2d 950 (5th Cir. 1976).

[3]"28 U.S.C. §1331, the jurisdictional base relied upon by the district court, is expressly negated as a possible source of jurisdiction by the third sentence of §450(h)." 526 F.2d at 953 n.2.

[4]42 U.S.C. §1395ii. Instead, a severely limited judicial review was provided, confined to decisions of the Secretary which reversed or modified (adversely to the provider) a Board decision. 42 U.S.C. §1395oo(f). This oversight, if such it was, was remedied when Congress amended the Medicare Act to establish full review of Provider Reimbursement Review Board determinations and reversals or affirmances by the Secretary in such cases as this arising on or after June 30, 1973. 42 U.S.C. §1395oo(f)(1) (Supp. III, 1970).

[5]*Salfi, supra* 422 U.S. at 757, 95 S.Ct. 2457.

provider of medicare services.[6] It may be that this is the intent and mandate of Congress; *Salfi* determined that it is as to the Social Security Act cases, though as to them the statutory scheme and language is clear, round and cohesive. If so, of course, that mandate must be obeyed.

Yet the spotty review of Medicare matters resulting from Congress' failure to incorporate §405(g), coupled with §405(h)'s specific assumption that *some* review has been provided, leaves the mind unsatisfied when confronted with a futile statutory attempt to review the Secretary's refusal to reopen and recalculate the amount of this provider's reimbursement. And dissatisfaction grows as we contemplate an apparently wayward preclusion of statutory review during a limited time frame, an hiatus remedied when Congress got around to the matter again. Several courts have labored mightily to avoid the irrational result which a mechanical construction of this peculiar statutory collage produces.

Our own now-overruled decision in *Ortego v. Weinberger*, 516 F.2d 1005 (5 Cir. 1975), was driven to ascertain APA jurisdiction even in a Social Security Act

[6]Section 1395ff(c) provides judicial review for a decision that an institution is not a provider of services and for a decision to terminate an institution's status as a provider. Provider Reimbursement Review Board determinations are not reviewable under this section but are covered in §1395oo. This section, when first enacted, only provided for judicial review of the Secretary's reversal or adverse modification of a Board determination. The amendment to that section in 1974 allowed judicial review of any final decision of the Board and of the Secretary's reversal, affirmance or modification of any Board decision (effective for accounting periods ending on or after June 30, 1973).

case, where the claimant was barred from statutory review by his failure to apply for the required hearing. In *Lejeune* we refused to interpret *Salfi* as denominating §405(g) an exclusive source of jurisdiction in those situations where §405(g) review was unavailable:

> The claims over which review was sought in *Salfi* were ones which could be reviewed judicially, after proper procedures were followed within the agency, under §405(g). Decisions of the Secretary which can be reviewed judicially under §405(g) can be reviewed judicially *only* under §405(g). §405(g) affords no jurisdiction over the Secretary's refusal, without a hearing, to reopen on the basis of new evidence a determination of ineligibility. *Salfi* did not discuss decisions of this type . . ..

526 F.2d at 953 n.2 (emphasis supplied). In *South Windsor Convalescent Home, Inc. v Mathews*, 541 F.2d 910 (2d Cir. 1976), the Second Circuit concluded that *Salfi* precluded federal-question jurisdiction in Medicare cases like this one but found jurisdiction to review existed in the Court of Claims. This it did on reasoning that although the last sentence of §405(h) forbade review under "section 41 of Title 28,"[7] it did not speak to 28 U.S.C. §1491, the Court of Claims provision. This analysis fails, however, to deal with what seems to us the equally preclusive language of the second sentence of §405(h): "No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal or

[7]The predecessor of 28 U.S.C. §1331, granting federal-question jurisdiction.

governmental agency except as *herein* provided." (Emphasis added). And the Eighth Circuit, in *St. Louis University v. Blue Cross Hosptial Service*, 537 F.2d 283 (8 Cir. 1976), a post-*Salfi* Medicare case, refused to find complete preclusion of federal question jurisdiction by §405(h), reasoning that constitutional claims must be reviewable despite §405(h) language to the contrary. With respect, we think the reasoning of our Brothers' careful opinion supports a more expansive result than they reached:

> Thus, we must now return to §405(h) to determine if it precludes our jursidiction to entertain a due process challenge to the procedures adopted by the Secretary to determine Medicare reimbursements. Section 405(h) forbids any action under §1331 "to recover on any claim arising under this subchapter." Appellees in *Salfi* argued that this did not bar their constitutional claims since they "arose under" the Constitution and not under the Social Security Act. The Supreme Court recognized that this argument had substance. 422 U.S. at 760, 95 S.Ct. at 2464, 45 L.Ed.2d at 536. However, it rejected the argument because
>
> > not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions. [*Id.* at 760 61, 95 S.Ct. at 2464, 45 L.Ed.2d at 536.]

The Court also indicated that its decision was influenced by the availability of fully adequate judicial review under §405(g). The Court said:

> In the present case . . . the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. *Thus* the plain words of §405(h) do not preclude constitutional challenges. [*Id.* at 762, 95 S.Ct. at 2465, 45 L.Ed.2d at 537 (emphasis added).]

In the present case, the due process claim has as its primary goal obtaining a constitutionally adequte hearing. Allowing such a hearing will not necessarily affect the University's entitlement to reimbursement or the amount allowed. Secondly, and more importantly, the Medicare Act does not provide the University an adequte alternative means of obtaining judicial review of its due process claim.

We believe that on these two grounds alone, this case is distinguishable from *Salfi*, and thus §405(h) does not preclude our jurisidiction of count II. However, there is a third basis for distinction. Section 405(h) is incorporated into the Medicare Act only "as . . . applicable." §1395ii. The general rule is that a statute incorporated into another "as applicable " will be read in such a manner "as will give form and effect to the statute into which it is incorporated." *Penrose v. Whiteacre*, 62 Nev. 239, 147 P.2d 887, 889 (1944), and authority cited therein. If §405(h) were read to wholly preclude

> adjudication of the University's due process claim it would raise serious constitutional problems which might impair the force and effect of the Medicare Act. Therefore, we find that Congress did not intend for §405(h) to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process.

537 F.2d at 291 92 (footnote omitted).

We agree that *Salfi*, a Social Security Act case, is distinguishable from and does not rule Medicare appeals. We also agree that §405(h), incorporated into the Medicare context, should be there read in such a manner as to give rational form and effect to the workings of the Medicare scheme. We therefore hold that during the period before it provided adequate statutory review within the Medicare Act, and during that period only, Congress did not intend §405(h) to preclude federal-question jurisdiction over such matters as this. We do so realizing that our construction is strained, but mindful as well that our duty is to seek legislative intent and not a barren form of words and in the belief that it is proper to consider the changing context of §405(h) in ascertaining its true meaning, albeit its own words remain constant.

The motion for rehearing is DENIED.

CLARK, Circuit judge, dissenting:

The majority is able to divine a congressional intent to grant court review of the Secretary's decisions in this Medicare matter. I am not.

The statue we interpret reads:

> The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

42 U.S.C. § 1395ii.

To give these number and subchapter references more meaning for the reader, I have paraphrased the statute in the following manner. "The provisions of certain parts of the Social Security Act shall also apply with respect to this Medicare Act to the same extent as they are applicable there. These parts include §405(h), which provides: 'The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.' This does not include §405(g), which grants the right of judicial review to a broad spectrum of the Secretary's final decisions under the Social Security Act."

We all must acknowledge that this court is bound by the United States Supreme Court's determination that for Social Security purposes the bar to judicial review of section 405(h) is "sweeping and direct" and effective. *Weinberger v. Salfi*, 422 U.S. 749, 757, 95 S.Ct. 2457, 2463, 45 L.Ed.2d 522 (1975). Indeed, the majority admits that no review may be had of the Secretary's ac-

tion in the case at bar under the literal language of Congress and *Salfi*. Yet a right of court review is found.

For the accounting periods relevant to this provider reimbursement dispute, 42 U.S.C. §1395ff(c) provided: "Any institution . . . dissatisfied with any determination by the secretary that it is not a provider of services, or with any determination [by the Secretary that an institution, which has qualified as a provider of services, is no longer eligible to maintain its provider status], shall be entitled . . . to judicial review of the Secretary's final decision . . . as is provided in Section 405(g) of this title [*i.e.*, 42 U.S.C. §405(g)]." Because of the disparity of these review rights in contrast to that specified in Social Security matters, the majority treats the omission of §405(g) from the list of Social Security Act provisions which were expressly incorporated as an "apparently wayward" congressional oversight which Congress later remedied by adopting 42 U.S.C. §1395*oo*(f). The majority draws sustenance for its position from the mightily labored efforts of some courts to find the power to review despite this legislative error.

Yet I do not see the congressional action in not listing §405(g) among those sections included in 42 U.S.C. §1395ii as necessarily evidencing a mistake. Congress *did* incorporate §405(g) into the Medicare Act. See 42 U.S.C. §1395ff(c). Congress limited the courts' right to review under 42 U.S.C. §405(g), however, to the two classes of determinations of the Secretary that are expressly set forth in 42 U.S.C. §1395ff(c). Thus §405(g)'s "omission" from 42 U.S.C. §1395ii makes perfectly good sense: It was incorporated into another portion of the Act. That Congress initially precluded judicial review of provider reimbursement disputes but later chose to per-

mit such review does not suggest that its initial decision was irrational. The desirability of assuring the correctness of the Secretary's decisions by allowing judicial review could well have been overbalanced in the legislative mind by the need for finality and economy of administration in this remedial Act.

The judicial role of inferior federal courts is limited to the jurisdiction expressly conferred by Congress. I see a great portent for danger to this basic concept if we are able to imply jurisdiction because we think it ought to exist where Congress has literally given none. Because I am convinced the majority exceeds its interpretive license, I respectfully dissent.

EXHIBIT C

DR JOHN T. MacDONALD FOUNDATION, INC., d/b/a Doctors' Hospital, a Florida Corporation not for profit, Plaintiff-Appellant,

v.

F. David MATHEWS, Secretary of Health, Education and Welfare, et al., Defendants-Appellees.

No. 75-2966.

United States Court of Appeals, Fifth Circuit.

July 2, 1976.

Appeal from the United States District Court for the Southern District of Florida.

Before DYER, CLARK and GEE, Circuit Judges.

GEE, Circuit Judge:

The Dr. John T. MacDonald Foundation, Inc., doing business as Doctors' Hospital, brought this suit for declaratory and injunctive relief to require HEW to reopen and recompute final administrative determinations of the Medicare program reimbursement due the hospital under Title XVIII of the Social Security Act, 42 U.S.C. §1395, et seq. (1974), for the years 1967 through 1972. During those years, Doctors' Hospital generated between $100,000 and $150,000 annual revenue by leasing its radiology department to a group of radiologists. HEW maintains that the hospital's Medicare reimbursement for those years must be reduced by the revenue from this lease; it relies on regulations set forth in 20 C.F.R. §405.486(b)(1) (1974). Doctors' Hospital maintains that the radiology department is not one of the departments of the hospital and that profits from its lease ought not reduce allowable costs generated by all other hospital departments. The district court granted summary judgment for defendants. We reverse, finding that HEW has misinterpreted its own regulation.

I. *Jurisdiction*

[1] We must first determine if the district court had jursdiction to hear this suit. 42 U.S.C. §405(h), expressly made applicable to the Medicare program by 42 U.S.C. §1395ii, provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

HEW asserts that §405(h) precludes jurisdiction of the district court under 28 U.S.C. §1331 and under the Administrative Procedure Act, §10. The Second Circuit has interpreted §405(h) to preclude judicial review only if the Medicare Act establishes some precedures for review of the Secretary's decision. *Kingsbrook Jewish*

Medical Center v. Richardson, 486 F.2d 663, 666-68 (2d Cir. 1973); *Aquavella v. Richardson*, 437 F.2d 397, 402 (2d Cir. 1971); *Cappadora v. Celebrezze*, 356 F.2d 1 (2d Cir. 1966) (interpreting §405(h) under the Social Security Act). Our court has adopted this reading of §405(h):

> Where an act provides procedures for judicial review, a court cannot review an agency decision by any other means; where the act does not provide such procedures, however, "nonstatutory" review is still available.

Ortego v. Weinberger, 516 F.2d 1005, 1009 (5th Cir. 1975), *citing Aquavella v. Richardson, supra.*[1] It is conceded that the Medicare Act does not provide for judicial review of the order in question in this case.[2]

[2] HEW contends that the Supreme Court decision in *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), nullifies the *Ortego* view of §405(h). *Salfi* found that §405(h) barred §1331 jurisdiction of a constitutional challenge to the requirement that a widow and stepchildren must have been related to a

[1]It should be noted that the Second Circuit's doctrine interpreting §405(h) was decided under a due process challenge; however, *Ortego* did not involve any constitutional challenges, and therefore this distinction should not bar jurisdiction in this case, which brings no constitutional challenge.

[2]Congress amended the Act to establish a Provider Reimbursement Review Board to determine controversies between a provider and an intermediary concerning the amount of reimbursement, but the amendment is effective only for accounting periods ending on or after June 30, 1973. 42 U.S.C. §1395oo (Supp. III, 1970).

wage earner nine months prior to his death to claim survivor benefits under the Social Security Act.[3] This strict interpretation of §405(h) in *Salfi* where judicial review was possible under §405(g) does not overrule our holding in *Ortego* that where no review procedures are provided jurisdiction exists under §10 of the APA.[4] As we noted in *Lejeune v. Mathews*, 526 F.2d 950 (5th Cir. 1976), *Salfi* was considered by the judges who wrote *Ortego*,[5] and we are bound by their construction of *Salfi*.

> Any language in the *Salfi* majority opinion which seems to characterize §405(g) as an exclusive source of jurisdiction over Social

[3]It should be noted, however, that at the same time that it interpreted §405(h) strictly, the Court rendered a loose interpretation of §405(g) to allow judicial review under that provision. This same approach was followed in *Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18, 44 U.S.L.W. 4224 (1976), which refused to find in *Salfi* a bar to §405(g) jurisdiction of an action seeking review of a decision of the Secretary of HEW to determine disability benefits under the Social Security Act.

[4]*Accord Sanders v. Weinberger*, 522 F.2d 1167 (7th Cir. 1975) (district court had jurisdiction, under the APA, to review for abuse of discretion a refusal to reopen the determination of ineligibility for Social Securuty benefits).

[5]The effect of *Salfi* on this jurisdictional question was also considered in *Sanders v. Weinberger*, supra, 522 F.2d [1167] at 1171 (7th Cir. 1975). The Secretary petitioned the *Ortego* panel for rehearing, presenting the same arguments based on *Salfi* which he now urges here. The petition was denied 516 F.2d 1005 (5th Cir. 1975). These arguments were also presented to the Seventh Circuit in a petition for rehearing *en banc* in *Sanders*, which petition was also denied. 522 F.2d 1167 (7th Cir. 1975).

Lejeune v. Mathews, 526 F.2d 950, 953 n. 1 (5th Cir. 1976).

Security cases must be read in the proper context. The claims over which review was sought in *Salfi* were ones which could be reviewed judicially, after proper procedures were followed within the agency, under §405(g). Decisions of the Secretary which can be reviewed judicially under §405(g) can be reviewed judicially *only* under §405 (g). §405(g) affords no jurisdiction over the Secretary's refusal, without a hearing, to reopen on the basis of new evidence of determination of ineligibility. *Salfi* did not discuss decisions of this type, and, as stated in *Ortego*, *Salfi* "gave no consideration to review of 'final agency action' pursuant to the terms of Section 10 of the Administrative Procedure Act." 516 F.2d at 1011 n. 4. *See also Sanders v. Weinberger, supra*, 522 F.2d at 1171. *Salfi* does not require us to hold that a refusal to reopen is a decision irretrievably committed to agency discretion. *Ortego*, decided after *Salfi*, requires us to hold otherwise.

Lejeune v. Mathews, 526 F.2d 950, 953 n. 2 (5th Cir. 1976). The law of this circuit, then, is that §405(h) is not an absolute bar to jurisdiction under the APA to review refusals of the Secretary to reopen decisions otherwise unreviewable.[6] Relying on *Ortego* and *Lejeune*, we find

[6]In two similar cases seeking to reopen and recompute Medicare reimbursements under the medical insurance program, the Eighth Circuit has interpreted *Salfi* as a bar to jurisdiction under §1331 and under §10 of the APA. *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir., 1976); *Faith Hosp. Ass'n v. Blue Cross Hosp. Serv.*, 537 F.2d 294 (8th Cir., 1976). In rejecting jurisdiction under the APA, the Eighth Circuit found that the

the district court had jurisdiction under §10 of the APA to hear this action.

II. *Reimbursement*

When an individual covered by Medicare is hospitalized, the hospital insurance program pays to the hospital the reasonable cost of its services, and the medical insurance program pays the attending physician the reasonable charges for his services. When a "hospital-based physician" leases space from the hospital and assumes the costs of operation of a certain department of the hospital, Medicare should not pay twice for the same hospital services — once to the hospital and again to the physician, whose fees will now include the operating costs of the hospital department. 20 C.F.R. §405.486(a) establishes that in the case of a "hospital-based physician" payment for hospital ser-

[6]—Continued

amount of reimbursement under the medical insurance program had been committed to agency discretion and therefore was not reviewable under the APA. 5 U.S.C. §701. We are here dealing with the amount of reimbursement under the hospital insurance program. We rely on the amendment establishing a Provider Reimbursement Review Board, *supra*, n. 2, as evidence that Congress did not intend to commit such decisions to agency discretion.

We do not here decide if jurisdiction under §1331 survives *Salfi*. In *Ortego*, the court rejected §1331 jurisdiction not because of *Salfi* but because the jurisdictional amount was not met. However, a footnote in *Lejeune*, discussing *Salfi*, intimates that §1331 "is expressly negated as a possible source of jurisdiction by the third sentence of §405(h)." *Lejeune v. Mathews, supra* at 953 n. 2. This may be true, but we note that in *Salfi* review was sought under §1331 for an order that *was* reviewable under §405(g), and this holding does not necessarily bar an action under §1331 in a provider reimbursement dispute that is not otherwise reviewable.

vices will be made only to the doctor through the medical insurance program. 20 C.F.R. §§405.486(b)(1) and (2) both deal with how to calculate reasonable charges of the hospital-based physician; the stated objective is to "bring about as little change as possible (in the normal case) in the compensation the physician receives for his services in the hospital." 20 C.F.R. §405.486(b)(1) (1974).

Doctors' Hospital leased out its radiology department, providing certain services (i.e., operating costs), such as utilities and janitorial services. The radiology department handled its own billing. The amount paid by the radiologists to the hospital exceeded operating expenses, netting the hospital a profit of $100,000 to $150,000 in each year from 1967 to 1972.[7] The Secretary of HEW relied on the following portion of 20 C.F.R. §485.486(b)(1)[8] to claim that reimbursement due the hospital for services provided by its other departments should be reduced by the profit from the radiology department:

> Where, however, a hospital initially pays some or all of the operating expenses of a hospital department (e.g., pays the salaries of nonprofessional personnel and purchases supplies and equipment), even though subsequently those items and services for which it pays the operating expenses are furnished for the use of

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[7]The three radiologists made lease payments of $13,500 annually and under a royalty agreement paid the hospital a percentage of the gross receipts. This arrangement produced the following revenues and expenditures for the years 1967 through 1972:

Year	Revenues From Lease and "Royalty Agreement"	Expenses Incurred in Operation of Radiology Department	Net Income To Hospital From Radiology Department
1967	$129,227.60	$29,617.00	$ 99,610.00
1968	151,011.04	30,253.00	120,758.04
1969	165,490.00	33,323.00	132,167.00
1970	200,896.00	50,998.00	149,898.00
1971	161,134.00	49,978.00	111,156.00
1972	161,133.00	54,789.00	106,344.00

[8]The regulation in full provides:

> The objective in determining reasonable charges where the physician bills patients directly is the same as that expressed in §405.485(a); to bring about as little change as possible (in the normal case) in the compensation the physician receives for his services in the hospital. Where the physician bills the patient directly, costs of operating the hospital department which are borne by the physician will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program; the hospital will receive reimbursement through the hospital insurance program for those costs, if any, which it incurs. Where, however, a hospital initially pays some or all of the operating expenses of a hospital department (e.g., pays the salaries of nonprofessional personnel and purchases supplies and equipment), even though subsequently those items and services for which it pays the operating expenses are furnished for the use of the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimbursable under the hospital insurance progr m as hospital costs, and are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program.
>
> 20 C.F.R. §485.486(b)(1) (1974).

> the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimbursable under the hospital insurance program as hospital costs, and are not to be reflected in reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program.

[3,4] This regulation exists to insure that Medicare does not pay twice for the same operating costs. But this is not a case where Medicare paid twice. The hospital was never reimbursed for any operating expenses of the radiology department. Therefore, we cannot agree with HEW that §405.486(b)(1) should be applied to reduce Medicare payments due to Doctors' Hospital. We read "initially pays" in the regulation to describe an outlay by the hospital that predates a "subsequent" leasing arrangement through which the physician assumes the operating costs. Such an initial outlay is a cost for which the hospital is reimbursed by Medicare; then if a subsequent lease payment by the physician reimburses the hospital for the same costs, *that* payment must be deducted from the hospital's allowable costs under the hospital insurance program. Such a deduction properly avoids double reimbursement to the hospital, once by Medicare and again by the physician. But Doctors' Hospital was never reimbursed for any operating costs of the radiology department and should not have to deduct any lease payments made by the physicians. This is the only interpretation of the language relied upon by HEW that meshes with the earlier portion of §405.486(b)(1):

> Where the physician bills the patient directly, costs of operating the hospital department which are borne by the physician will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program; the hospital will receive reimbursement through the hospital insurance program for those costs, if any, which it incurs.

Medicare paid only the reasonable charges of the radiologists, although these charges were calculated to include the operating costs of the radiology department. What HEW complains of is that Medicare also paid in excess of $100,000 pure profit to the hospital each year because the physicians' fees necessarily included this expense, as well as the operating expenses. By allowing the doctors to charge enough to cover the cost of their lease, HEW complains that Medicare had to pay more than if it had separately paid the hospital under the hospital insurance program and the doctors under the medical insurance program.

Doctors' Hospital agrees that HEW should not pay for the hospital's pure profit, but it contends that §405.486(b)(2),[9] which governs the manner of cal-

[9]The regulation in full provides:

> Where a hospital has been receiving, as its portion of the receipts for such services, significantly more or less than the costs the hospital has incurred in the provision of the services, this excess or shortage should not be transferred from the hospital to the physician merely because he decides to bill his patients directly. Since payment to the hospital is made on the basis of its reasonable costs for all hospital services, the transfer of such excess of shortage to the physician necessarily would alter the total cost of patient hospital

culating reasonable charges for hospital-based physicians, spells out the proper way to avoid paying such profit.

> The reasonable charges of a physician who enters into a lease or similar arrangement with a hospital under which the physician assumes the costs of operating the department and bills the patients directly would be based upon the remuneration he received for his services immediately prior to the leasing arrangement plus his reasonable costs of operation, taking into account the hospital's cost experience in providing such services.

[9]—Continued

and medical care—a result which the legislation was not intended to bring about. The reasonable charges of a physician who enters into a lease or similar arrangement with a hospital under which the physician assumes the costs of operating the department and bills the patients directly would be based upon the remuneration he received for his services immediately prior to the leasing arrangement plus his reasonable costs of operation, taking into account the hospital's cost experience in providing such services. Reasonable charges, so determined, would be subject to appropriate future adjustment to take into account changing economic factors. Reference back to the remuneration formerly received by the physician from the hospital as a factor in determining his reasonable charges under the lease or similar arrangement is required to give effect to the provisions of the statute which direct that consideration be given, in determining reasonable charges, to the customary charges generally made by the physician for similar services. Where no pattern of customary charges has been established for the physician's professional services to patients other than the compensation he received from the hospital for his services, such compensation would serve as the basis for establishing the customary charge.
20 C.F.R. §405.486(b)(2) (1974).

Thus, a hospital-based physician who pays his own operating costs can include his operating costs in calculating his fee, but his reasonable charge would be "actual cost" based on the hospital's cost experience, plus prior charges by a physician for similar services; it may not include money paid to the hospital in excess of actual operating costs.

HEW argues that C.F.R. §405.486(b)(2), with its restriction on what can be paid to doctors under the medical insurance program, cannot control an operating expense that includes operating costs plus a profit to the hospital. The problem is that this regulation fails to distingiush between "operating costs," meaning the costs of providing services, and "overhead," the cost of the lease plus the price for obtaining a monopoly on radiology work in the hospital. To avoid §405.486(b)(2), HEW argues that this section does not apply to the hospital-based physician whose lease includes a payment for operating costs, i.e., where the hospital pays the operating costs and is then repaid by the physician through his lease. To say that this physician is not paying his operating costs is to play games with words. The radiologists of Doctors' Hospital fit the description of hospital-based physicians, and HEW must rely on its regulation restricting the reasonable charges that can be paid such physicians. If C.F.R. §405.486(b)(2) is not an effective check on the payment of excessive overhead as a component of a hospital-based physician's reasonable charges, then the Secretary of HEW must promulgate a regulation that will correct such excesses rather than torture the sense of those he has. As now written, the regulation does not permit the Secretary to snatch revenue from the radiology department out of the hospital's pocket after the money has left the doctors'

hands. Nor may HEW apply C.F.R. §405.486(b)(1), designed as a safeguard against double reimbursement of the same operating costs, to a hospital which received no reimbursement under the hospital insurance program for the operation of its radiology department.

Section 10(e) of the APA requires reviewing courts to

> (2) hold unlawful and set aside agency action, findings, and conclusions found to be —
>
> (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

5 U.S.C §706 (Supp. II, 1967). We conclude that HEW abused its discretion in interpreting §405.486(b)(1) to require a deduction in provider reimbursements. We reverse and order HEW to reopen and recalculate the amount of reimbursement due Doctors' Hospital for the years 1967 through 1972 in light of this opinion.

REVERSED.

EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

Civil Action No. 74-1134-CIV-WM

In The Matter of:

Dr. John T. MacDonald Foundation, Inc., d/b/a Doctors' Hospital, a Florida Corporation not for profit

Plaintiff

vs.

Caspar Weinberger, Secretary of Health, Education and Welfare, et. al.

Defendants

FINAL SUMMARY JUDGMENT

Plaintiff, Dr. John T. MacDonald Foundation, Inc., d/b/a Doctors' Hospital, a Florida nonprofit corporation, brought this action seeking declaratory and injunctive relief against the Secretary of Health, Education and Welfare (Secretary), Blue Cross Association (BCA) and Blue Cross of Florida, Inc. (BCF) to require defendants to reopen and recompute the reinbursement due plaintiff under the "Medicare" program, Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq. (Act). The complaint and supplemental complaint allege that the defendants acted in excess of their statutory jurisdiction, authority or limitation under the Act in disallow-

ing certain amounts as reimbursable costs for the years 1967-1972.

Both plaintiff and defendants have now moved for summary judgment. Having considered the motions for summary judgment, together with the briefs and materials submitted by the parties in support of their motions, it appears that there are no genuine issues of material fact and that defendants are entitled to judgment as a matter of law, based on the following facts and conclusions of law:

FINDINGS OF FACT

Material Facts as to Which There Is No Genuine Issue

1. Plaintiff is a 230 bed, acute, general short-term, non-profit hospital.

2. During its fiscal years 1967 and 1968, the plaintiff leased a portion of its premises to a group of radiologists who conducted a practice of radiology on the leased premises. Pursuant to the terms of the lease agreement, the plaintiff paid certain costs incidental to the operation of the radiology department. The plaintiff never billed the Medicare Program for these costs or any other costs incurred in connection with the radiology department. Instead, the plaintiff used lease revenues to pay all of the plaintiff's costs incurred in connection with the radiology department and was left with net income from the leasing arrangement during its fiscal years 1967 and 1968.

3. Pursuant to an agreement with the Secretary, plaintiff became a participating provider of services under Title XVIII of the Act as of July, 1966. BCA agreed pursuant to section 1816 of the Act, 42 U.S.C. §1395h, to perform designated functions in the administration of Part A of the statutory program and then delegated its duties as a fiscal intermediary to BCF.

4. As a participating provider of services, plaintiff is required to file annual cost reports with the intermediary as a basis for determinations of the amounts payable to the provider under Part A. 20 C.F.R. §405.406(b). In making such a determination, BCF offset revenue from plaintiff's leased radiology department against all of the hospital's reimbursable costs. This action resulted in a disallowance of reimbursable costs of $120,758 in 1967 and $99,611 in 1968. In taking this action, BCF relied upon a regulation promulgated by the Secretary, 20 C.F.R. §405.486(b)(1).

5. BCA established a Providers' Appeals Committee (Committee) to resolve appeals from providers dissatisfied with determination of program reimbursement by intermediaries.[1] Plaintiff requested a hearing before the Committee, and a hearing was held before a panel of BCA Medicare Provider Appeal Hearing Officers on May 22, 1974 at which plaintiff was represented by its

[1]Hearing procedures are required by regulation for cost reporting periods on or after December 31, 1971. See 20 C.F.R. §405.490. However, some intermediaries have previously established appeals procedures for resolving disputes with providers and, in addition, BCA had developed a procedure for resolving disputes between a provider and one of its member Plans. See CCH UIR Fed. para. 13,510.

counsel, its administrator and its certified public accountant.

6. On the basis of the evidence presented at the hearing, the Committee upheld the decision of BCF. The basis of this decision was that the wording of section 405.486(b)(10 of the regulations, 20 C.F.R. §405.486 (b)(1), was clear and that it required offsetting revenue from leased departments against all allowable costs, not just allowable department costs.

7. The BCF Committee decision was transmitted to plaintiff on July 1, 1974. No further administrative remedies are available to plaintiff and the decision of the Committee is final.

8. During its fiscal years 1969, 1970, 1971, and 1972, the plaintiff continued its practice of leasing the radiology department to the same doctors and again the plaintiff received net income from the leasing of that facility. Just as in the past, BCF decided that the net income from leasing this department must be used to offset costs incurred by plaintiff which were otherwise reimbursable under the Medicare Program. The plaintiff requested a hearing pursuant to 20 C.F.R. §405.492 (1974), before another Provider Appeals Committee of Blue Cross (Committee).

9. By letter dated December 17, 1974, several months after the filing of the Complaint in the instant case, the Committee informed the plaintiff that it was taking the same position with respect to net income from the leasing of the radiology department for the years 1969, 1970, 1971, and 1972 as it had in its previous ruling with respect to the years 1967 and 1968. Since the

plaintiff now has no further administrative remedies with respect to BCA's decision to disallow the plaintiff's cost reimbursement under the Act for the amount of the net income from the lease of the radiology department during the years 1969 through 1972, it sought and was granted leave to file its Supplemental Complaint adding those four years to this litigation.

10. The factual details surrounding the lease of the radiology department during the years 1969 through 1972 are set forth in the plaintiff's position paper which has been annexed to its Supplemental Complaint. BCA has stipulated to the truth of the facts and genuineness of the documents set forth in that position paper.

Conclusion of Law

1. In reviewing the facts as set forth above, the Court finds that it has jurisdiction pursuant to the following federal laws: 5 U.S.C. §§701-706 (Administrative Procedure Act); 28 U.S.C. §1331(a) (Federal Question); and 28 U.S.C. §§2201-2202 (Declaratory Judgment). The amount in controversy exceeds $10,000 exclusive of interest, costs and attorneys' fees.

2. It is clear from the record that administrative due process was afforded plaintiff by the hearing provided by the BCA Providers' Appeals Committee, and plaintiff has not contended otherwise. See *Wilson Clinic & Hospital, Inc. v. Blue Cross of South Carolina*, 494 F.2d 50 (4th Cir. 1974); *Russi v. Weinberger*, 373 F. Supp. 1349 (E.D. Va. 1974).

3. Plaintiff attacks the Secretary's interpretation of 20 C.F.R. §405.486(b)(1) and thus has:

> "The burden facing one who seeks to overturn the interpretation and administrative application accorded by an administrative agency 'to a regulation by showing' that the interpretation is not reasonable and the application lacks rational justification."

Gulf Oil Corporation v. Hickel, 435 F.2d 440, 444 (D.C. Cir. 1970), *citing Pancoastal Petroleum, Ltd. v. Udall,* 348 F.2d 805, 807 (D.C. Cir. 1965).

4. Plaintiff contends that the proper interpretation of 20 C.F.R. §405.486(b)(1) is that payments received by a hospital from a physician in connection with the lease of a hospital department by that physician need only be offset against the costs incurred by the hospital in connection with that particular department and that the action of BCF in disallowing reimbursement for costs equal to the amount of plaintiff's receipts from operation of the department was in excess of its authority. In the alternative, plaintiff contends that the regulation conflicts with 42 U.S.C §§1395(b), (c), (g) and (x)(c)(1)(A).

5. Plaintiff's contention is that the words "allowable costs" in the regulation should be read as "allowable departmental costs." The Secretary is the best judge of the meaning of his regulations. See *Sullivan v. Weinberger,* 493 F.2d 855, 860 (5th Cir. 1974). In addition, plaintiff's construction contravenes both the plain meaning of the phrase utilized and its interpretation in light of 20 C.F.R §405.486 and related regulations.

6. The term "allowable costs" plainly refers to those types of provider costs reimbursable pursuant to the Medicare Program. See CCH Medicare and Medicaid Guide, p. 1619. In contrast, references to departmental costs in the regulation are distinctly indicated by the terms "cost of operating the hospital department," "operating expenses of a hospital department," and "such operating costs." 20 C.F.R. §405.486.

7. The meaning of the term "allowable costs" is even more obvious in light of its use in other regulations. Items included and excluded in the term are set forth in 20 C.F.R. §405.402(c). "Allowable costs" are costs recognized under the program, as opposed to the apportionment of such costs to determine the share of costs to be borne by Title XVIII. See 20 C.F.R. §405.403(a). There can be no doubt whatsoever that the term "allowable costs" appearing in 20 C.F.R. §405.486(b)(1) was correctly interpreted in plaintiff's case as referring to all reimbursable costs of the plaintiff.

8. In reviewing the adoption of the regulation itself by the agency under its rule-making procedures, the Court is limited to considering whether the administrative action was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law. *Federation of Homemakers v. Hardin,* 328 F.Supp. 181, 184 (D.D.C. 1971); *American Bible Soc. v. Blount,* 446 F.2d 588, 497 (2d Cir. 1971); 5 U.S.C. §7062(s)(A). Accordingly, plaintiff here has to overcome "the venerable principle that the construction of a statute by those charged with its execution should be followed unless

there are compelling indications that it is wrong . . ." *Red Lion Broadcasting Co., Inc. v. Federal Communications Commission*, 395 U.S. 367, 381 (1969). See also, *Kroll v. Cities Service Oil Co.*, 352 F. Supp. 357 (N.D. Ill. 1972).

9. Plaintiff argues that the regulation in question is not "reasonably related to the purposes of the enabling legislation." *Johnson's Professional Nursing Home v. Weinberger*, 490 F.2d 841, 844 (5th Cir. 1974), *quoting Thorpe v. Housing Authority*, 393 U.S. 268, 280-281 (1968). Plaintiff recognizes that "the purpose of the Medicare legislation is to reimburse a provider for "reasonable cost," defined as:

> "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; . . . "
>
> 42 U.S.C.A. §1395 (x)(v)(1)(A) (1974).

However, Plaintiff argues that the regulation of the Secretary violates the purpose of the Act's prohibition in §1395 of supervision or control by federal officers over the administration or operation of the provider.

10. Plaintiff interprets the prohibition of supervision or control as forbidding regulation of a provider's "profit." However, the Secretary's methods of determination of what constitutes reasonable cost is not an exercise of supervision or control over the administration or operation of the provider, but merely a determination of the reimbursement to which the provider is entitled under the Act as its "reasonable costs." The Secretary has not forbidden plaintiff to make any administrative arrangement with physicians it desires, but has only determined that the lease arrangement devised by plaintiff will result in an offset against allowable costs in the determination of reasonable costs. The Secretary has authority to set such payment limits. *Johnson's supra.*

11. Plaintiff further argues that the regulation does not serve the purpose of assuring the correct computation of reasonable cost because by reimbursing the radiologists their reasonable charges under Part B of the Act, Medicare will have paid all costs reasonably related to the delivery of radiology services. It is argued that so long as the provider does not bill the Medicare program for costs allocable to the radiology department, there is no purpose served in offsetting payments the provider receives relating to those services, since the program will have paid only once for services relating to radiology. However, as section 405.486(b)(2) of the regulations points out, a provider's reimbursement for reasonable costs is based on the reasonable costs for *all* hospital services. Plaintiff's argument is therefore without merit.

12. The Secretary has determined that the effect of lease arrangements such as the one here alter the total cost of patient care, and the Court is not convinced that the regulation providing for reduction of allowable costs to the provider by the amount of revenue from the provider's leased radiology department is arbitrary,

capricious, an abuse of discretion or not in accordance with the purposes of the Act.

13. The Court finds that the action of the defendants is in accord with 20 C.F.R. §405.486 and that plaintiff has failed to prove that the regulation of the Secretary is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the policy of the Act. Accordingly, it is

ORDERED and ADJUDGED that:

1. The motions of defendants for summary judgment be and the same are hereby GRANTED. In the absence of any genuine dispute of material fact, and defendants being entitled to a favorable judgment as a matter of law, summary final judgment is hereby ordered entered in favor of defendants and against the plaintiff.

2. Plaintiff's motion for summary judgment be and the same is hereby DENIED, there being no material facts in dispute as to defendants' compliance with Title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.

DONE and ORDERED at Miami, Florida, this 29 day of May 1975.

W. O. MEHRTENS
United States District Judge

EXHIBIT E

No. 290

BLUE CROSS ASSOCIATION
MEDICARE PROVIDER APPEAL DECISION
DISPUTE BETWEEN
DOCTOR'S HOSPITAL
PROVIDER NO. 10-0020
AND
BLUE CROSS OF FLORIDA, INC.

This provider appeal of a dispute between a hospital and a Blue Cross Plan ("Plan") was heard by a panel of Blue Cross Association ("BCA") Medicare Provider Appeal Hearing Officers ("Panel") on May 22, 1974, James T. Goodman, BCA, presiding. The other members of the Panel were Donald W. Cordes, American Hospital Association, and Marvin R. Hurwitz, BCA. The Provider was represented by its counsel, its administrator, and its certified public accountant. The decision of the Panel was based upon the provider's oral presentations to the Panel and responses to their questions, the Plan's responses to questions put to it by the Provider and Panel and the documents furnished the Panel before and during the hearing.

The Provider is a 230-bed, acute, general short-term, non-profit hospital with Medicare utilization of 35.75% during 1967 and 36.5% during 1968.

This dispute concerned the correct interpretation of Regulation Section 405.486(b)(1), and in particular, the last sentence which states that, "Any payments received by the hospital under such an arrangement [leased

department] shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program." The Plan interpreted this Regulation to mean that any payments received by the hospital under a lease arrangement between a hospital-based physician and a hospital shall be used to reduce *all* allowable costs of the hospital. The Provider read the sentence to mean that such payments shall be used to reduce the allowable *departmental* costs of a hospital.

As a result of the Plan's interpretation of this Regulation, it offset revenue from the Provider's leased radiology department against the balance of the Provider's allowable costs. This amounted to a denial of $120,758 in 1967 and $99,611 in 1968.

The Provider gave three reasons why the Plan's interpretation was erroneous. First, the guidelines contained in HIM-15 concerning reimbursement of hospital-based physicians make it clear that the phrase "reduction in allowable costs" means reduction of allowable departmental costs. The Provider argued that the purpose of Section 2108.6 of HIM-15 is to ensure that the Medicare program does not make duplicate payments for the same service to both physicians and providers. This purpose is no longer served if the Plan's interpretation of Section 405.486(b)(1) is upheld. Since Part B does not bear a portion of a provider's indirect costs when it pays radiologist's fees, a provider's share of the Part B revenue should only reduce departmental charges. Second, the Provider argued that the Section at issue must be construed to mean reduction of departmental costs in order to be consistent with the manner in which other revenues are offset against other costs under the Medicare Regulations. For example, in-

come from gift, flower and coffee shops ordinarily does not reduce total hospital costs. Parking lot revenue is applied against parking lot costs, but not against other allowable costs. Third, the Provider argued that Section 405.486(b)(1) is invalid, unless construed to require only a reduction of departmental costs by revenues received from hospital-based physicians. To the extent revenues received from hospital-based physicians are applied against a provider's general operating costs, other than those of the applicable department, Part A costs are reduced so as to cause individuals not covered by Medicare to bear the costs of delivering services to Medicare beneficiaries in direct violation of the Act.

The Panel decides unanimously to uphold the Plan's interpretation of Regulation Section 405.486(b)(1). The Panel believes the wording of this Regulation is clear; it requires offsetting revenue from such leased departments against all allowable costs, not just allowable department costs. The Panel finds, as a matter of construction, that other sections specifically limit the offset to departmental costs, and that if that were the intent in the case of this Section, the draftsman would have specifically limited the offset to departmental costs. Therefore, in the absence of an expressed intention to limit the offset to the extent of departmental costs, the Panel must concur in the Plan's interpretation of this Section.

EXHIBIT F

No. 335

BLUE CROSS ASSOCIATION
MEDICARE PROVIDER APPEAL DECISION
DOCTOR'S HOSPITAL
PROVIDER NO. 10-0020
APPEAL FROM COST REPORT ADJUSTMENTS
MADE BY
BLUE CROSS OF FLORIDA, INC.

This provider appeal of cost report adjustments made by a Blue Cross Plan (Plan) was heard by Blue Cross Association Chief Hearing Officer James M. Gaynor on November 4, 1974. The appeal was heard on the basis of the written record, which included submissions from the provider and Plan as well as the record and decision in a prior appeal.

The provider is a 230-bed, acute, general short-term, nonprofit hospital with Medicare utilization of 38.3%, 36.8%, 37.1%, and 37.6%, respectively, for the fiscal years ended November 30, 1969, 1970, 1971, and 1972.

The issue under appeal concerns the correct interpretation of Regulations Section 405.486(b)(1), and in particular the last sentence, which states that, "any payments received by the hospital under such an arrangement [leased department] shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program." The Plan interpretated this to mean that any revenues received by the provider under its lease agreement with hospital

based physicians should be used to reduce *all* allowable costs of the provider. The provider read the pertinent statement to mean that such payments should be used to offset only the allowable costs of the *leased department.*

The amounts in question for the FYE's, 1969, 1970, 1971, and 1972 are $132,167, $149,898, $111,156, and $106,344, respectively. The total represented by these figures is $499,565.

The same issue, concerning the fiscal years ending November 30, 1967 and 1968, was the subject of an appeal heard by a panel of Blue Cross Association Hearing Officers on May 22, 1974, and published as decision No. 290. The facts of the prior appeal are the same as for this appeal, and the Hearing Officer has no reason to differ from that result. The decision of the Panel in that appeal is, therefore, adopted as the decision of the Hearing Officer for the appeal of the fiscal years 1969 through 1972.

The text of that decision is as follows:

> "As a result of the Plan's interpretation of this Regulation, it offset revenue from the Provider's leased radiology department against the balance of the Provider's allowable costs. This amounted to a denial of $120,758 in 1967 and $99,611 in 1968.
>
> "The Provider gave three reasons why the Plan's interpretation was erroneous. First, the guidelines contained in HIM-15 concerning

reimbursement of hospital-based physicians make it clear that the phrase "reduction in allowable costs" means reduction of allowable departmental costs. The Provider argued that the purpose of Section 2108.6 of HIM-15 is to insure that the Medicare program does not make duplicate payments for the same service to both physicians and providers. This purpose is no longer served if the Plan's interpretation of Section 405.486(b)(1) is upheld. Since Part B does not bear a portion of a provider's indirect costs when it pays radiologist's fees, a provider's share of Part B revenue should only reduce departmental charges. Second, the Provider argued that the Section at issue must be construed to mean reduction of departmental costs in order to be consistent with the manner in which other revenues are offset against other costs under the Medicare Regulations. For example, income from gift, flower and coffee shops ordinarily does not reduce total hospital costs. Parking lot revenue is applied against parking lot costs, but not against other allowable costs. Third, the Provider argued that Section 405.486(b)(1) is invalid, unless construed to require only a reduction of departmental costs by revenues received from hospital-based physicians. To the extent revenues received from hospital-based physicians are applied against a provider's general operating costs, other than those of the applicable department, Part A costs are reduced so as to cause individuals not covered by Medicare to bear the costs of delivering ser-

vices to Medicare beneficiaries in direct violation of the Act.

"The Panel decides unanimously to uphold the Plan's interpretation of Regulation Section 405.486(b)(1). The Panel believes the wording of this Regulation is clear; it requires offsetting revenue from such leased departments against all allowable costs, not just allowable department costs. The Panel finds, as a matter of construction, that other sections specifically limit the offset to departmental costs, and that if that were the intent in the case of this Section, the draftsman would have specifically limited the offset to departmental costs. Therefore, in the absence of an expressed intention to limit the offset to the extent of departmental costs, the Panel must concur in the Plan's interpretation of this Section."

EXHIBIT G

	Name of Case	Court	Status	Amount in Controversy
1.	*Alabama Hospital Association v. Weinberger, et al.*	5th Cir. 76-4076	On Appeal	$670,000.00
2.	*American Association of Councils of Medical Staffs of Private Hospitals, Inc. v. Mathews* (2 cases)	5th Cir. 76-4156	Briefed, Pending Argument	Unknown
3.	*Berdick v. U.S.* (2 cases)	S.D. Fla. 77-1652	To Be Answered	$110,000.00
4.	*Daytona Beach General Hospital v. Weinberger*	M.D. Fla. 74-055	Settlement Being Discussed	$483,403.00
5.	*Flanagan & Wiley v. Califano*	N.D. Texas 3-77-0786	Answer To Be Filed	$ 25,725.00
6.	*Gulf Coast Home Health Services v. Mathews*	M.D. Fla. 76-991	Motion To Dismiss Pending	$274,000.00
7.	*Harris Hospital v. Group Hospital Service, Inc.*	N.D. Texas CA-4-74-224	Motion For Dismissal & Summary Judgment Pending	$129,738.00
8.	*Hatcher v. U.S.A.*	N.D. Texas 4-76-17	Stayed Pending Criminal Case	$ 15,812.00
9.	*Herberman v. Blue Cross of Texas*	W.D. Texas EP-77-CA-67	Motion To Dismiss Pending	$ 1,630.10

	Name of Case	Court	Status	Amount in Controversy
10.	*Home Health Services of Texas v. Mathews*	S.D. Texas 73-H-1010	Settlement Negotiation In Progress	$ 74,708.00
11.	*Homan & Crimen, Inc. v. Mathews*	W.D. Texas EP 75-CA-265	Motions Pending To Dismiss And For Summary Judgment	$ 30,468.50
12.	*Home Health Care Agency of North Alabama v. Mathews*	N.D. Ala. 77-P-0017-S	Appeal Filed 3/31/77	$ 11,222.00
13.	*Home Health Services of Louisiana v. Mathews*	E.D. La. 76-2906	Remanded For Administrative Hearing	Unknown
14.	*Hospital Association of Conecuh County v. Secretary*	S.D. Ala. 74-196-H	In U.S.D.C. S.D. Ala.	$ 50,382.00
15.	*Inglewood, Inc. v. Mathews*	S.D. Miss. J75-280CRI	Negotiation Of Dismissal Currently Taking Place	$ 26,800.00
16.	*Dr. John T. MacDonald v. Weinberger*	5th Cir. 75-2966	Fifth Circuit Pending Petition For Rehearing *en bane*	$220,369.00
17.	*Matranga v. Travelers Insurance Co.*	S.D. Miss. J-75-344C	Pending On Jurisdictional Motion	$250,000.00
18.	*McLoughlin v. Mathews*	E.D. La. 76-2688-F	Remand For Administrative Hearing	$ 1,275.00

	Name of Case	Court	Status	Amount in Controversy
19.	*Moody Nursing Home, Inc. v. United Hospital Service*	5th Cir. 77-1322	On Appeal By Plaintiff To Fifth Circuit	Unknown
20.	*Mt. Sinai Hospital of Greater Miami v. Weinberger*	S.D. Fla. 73-804-CIV-WMH	Motion To Dismiss Pending	$ 6,380,000
21.	*O'Keefe v. Secretary*	S.D. Miss. 576-338(N) 576-339(R) 576-340(C)	Motion To Dismiss For Jurisdiction	$ 8,923.00
22.	*Pacemaker Monitor Corp. v. DHEW*	S.D. Fla. 77-807-CIV-JLK	Motion To Dismiss Filed 6/13/77	Unknown
23.	*Parkway General Hospital, Inc. v. Weinberger*	S.D. Fla. 76-181-Civ.-CF	Motions Pending To Disqualify Counsel And To Dismiss For Lack Of Subject Matter Jurisdiction	$122,229.00
24.	*Rutherford General Hospital v. Blue Cross Association*	N.D. Texas CA3-77-0060-C	Answer Filed, Motion For Summary Judgment In Preparation	$127,249.00
25.	*Stevens Park Osteopathic Hospital, Inc. v. Group Hospitalization, Inc.*	N.D. Texas 3-75-1433-G	Motions Pending To Dismiss And For Summary Judgment	$209,671.00

	Name of Case	Court	Status	Amount in Controversy
26.	*Szekely v. Weinberger*	S.D. Fla. 73-720-Civ-JE	Motion To Dismiss On Jurisdiction; Motion For Summary Judgment	$ 17,500.00
27.	*Thomas v. Mathews*	S.D. Fla. 77-125-Civ-JE	Motion To Dismiss Denied. Pending On Merits.	$108,916.00
28.	*Unicare, Inc. v. Secretary*	D.C.D.C. 76-2329-Civ-JE	Motion To Dismiss On Mootness Being Prepared	$427,807.00

28 U.S.C. §41 (1940)

Sec.

41. Original jurisdiction.

Par. 1. United States as plaintiff; civil suits at common law or in equity.
2. Crimes and offenses.
3. Admiralty causes, seizures, and prizes.
4. Suits under laws relating to slave trade.
5. Cases under internal revenue, customs, and tonnage laws.
6. Suits under postal laws.
7. Suits under patent, copyright, and trade-mark laws.
8. Suits under interstate commerce laws.
9. Penalties and forfeitures.
10. Suits on debentures.
11. Suits for injuries on account of acts done under laws of United States.
12. Suits concerning civil rights.
13. Suits against persons having knowledge of conspiracy.
14. Suits to redress deprivation of civil rights.
15. Suits to recover certain offices.
16. Suits against national banking associations.
17. Suits by aliens for torts.
18. Suits against consuls and vice consuls.
19. Suits and proceedings in bankruptcy.
20. Suits against United States.
21. Suits for unlawful inclosure of public lands.

22. Suits under immigration and contract labor laws.
23. Suits against trusts, monopolies, and unlawful combinations.
24. Suits concerning allotments of land to Indians; decrees; appeal.
25. Partition suits where United States is joint tenant.
26. Original jurisdiction of bills of interpleader, and of bills in the nature of interpleader.
27. Enforcement of orders of Interstate Commerce Commission.
28. Setting aside order of Interstate Commerce Commission.

42. Original jurisdiction of action by or against corporation incorporated under Act of Congress.
43. Venue of suits relating to orders of Interstate Commerce Commission.
44. Procedure in certain cases under interstate commerce laws; service of processes of court.
45. District courts; practice and procedure in certain cases.
45a. Special attorneys; participation by Interstate Commerce Commission; intervention.
46. Suits to enjoin orders of Interstate Commerce Commission to be against United States.
47. Injunctions as to orders of Interstate Commerce Commission; appeal to Supreme Court; time for taking.
47a. Appeal to Supreme Court from final decree; time for taking; priority.
48. Suits to be against United States; intervention by United States.
49. Appellate jurisdiction; Chinese exclusion laws.

§41. (Judicial Code, section 24.) Original jurisdiction.

The district courts shall have original jurisdiction as follows:

(1) United States as plaintiff; civil suits at common law or in equity.

First. Of all suits of a civil nature, at common law or in equity, brought by the United States, or by any officer thereof authorized by law to sue, or between citizens of the same State claiming lands under grants from different States; or, where the matter in controversy exceeds, exclusive of interest and costs, the sum or value of $3,000, and (a) arises under the Constitution or laws of the United States, or treaties made, or which shall be made, under their authority, or (b) Is[1] between citizens of different States, or citizens of the District of Columbia, the Territory of Hawaii, or Alaska, and any State or Territory, or (c) is between citizens of a State and foreign States, citizens, or subjects. No district court shall have cognizance of any suit (except upon foreign bills of exchange) to recover upon any promissory note or other chose in action in favor of any

[1]So in original. Probably should read "is".

assignee, or of any subsequent holder if such instrument be payable to bearer and be not made by any corporation, unless such suit might have been prosecuted in such court to recover upon said note or other chose in action if no assignment had been made. The foregoing provision as to the sum or value of the matter in controversy shall not be construed to apply to any of the cases mentioned in the succeeding paragraphs of this section. Notwithstanding the foregoing provisions of this paragraph, no district court shall have jurisdiction of any suit to enjoin, suspend, or restrain the enforcement, operation, or execution of any order of an administrative board or commission of a State, or any rate-making body of any political subdivision thereof, or to enjoin, suspend, or restrain any action in compliance with any such order, where jurisdiction is based solely upon the ground of diversity of citizenship, or the repugnance of such order to the Constitution of the United States, where such order (1) affects rates chargeable by a public utility, (2) does not interfere with interstate commerce, and (3) has been made after reasonable notice and hearing, and where a plain, speedy, and efficient remedy may be had at law or in equity in the courts of such State. Notwithstanding the foregoing provisions of this paragraph, no district court shall have jurisdiction of any suit to enjoin, suspend, or restrain the assessment, levy, or collection of any tax imposed by or pursuant to the laws of any State where a plain, speedy, and efficient remedy may be had at law or in equity in the courts of such State. (Mar. 3, 1911, ch. 231, §24, par. 1, 36 Stat. 1091; May 14, 1934, ch. 283, §1, 48 Stat. 775; Aug. 21, 1937, ch. 726, §1, 50 Stat. 738; Apr. 20, 1940, ch. 117, 54 Stat. 143.)

(2) Crimes and offenses.

Second. Of all crimes and offenses cognizable under the authority of the United States. (Mar. 3, 1911, ch. 231, §24, par. 2, 36 Stat. 1091.)

(3) Admiralty causes, seizures, and prizes.

Third. Of all civil causes of admiralty and maritime jurisdiction, saving to suitors in all cases the right of a common-law remedy where the common law is competent to give it, and to claimants for compensation for injuries to or death of persons other than the master or members of the crew of a vessel, their rights and remedies under the workmen's compensation law of any State, District, Territory, or possession of the United States, which rights and remedies when conferred by such law shall be exclusive; of all seizures on land or water not within admiralty and maritime jurisdiction; of all prizes brought into the United States; and of all proceedings for the condemnation of property taken as prize. The jurisdiction of the district courts shall not extend to causes arising out of injuries to or death of persons other than the master or members of the crew, for which compensation is provided by the workmen's compensation law of any State, District, Territory, or possession of the United States. (Mar. 3, 1911, ch. 231, §24, par. 3, 36 Stat. 1091; Oct. 6, 1917, ch. 97, §1, 40 Stat. 395; June 10, 1922, ch. 216, §1, 42 Stat. 634.)

(4) Suits under laws relating to slave trade.

Fourth. Of all suits arising under any law relating to the slave trade. (Mar. 3, 1911, ch. 231, §24, par. 4, 36 Stat. 1092.)

(5) Cases under internal revenue, customs, and tonnage laws.

Fifth. Of all cases arising under any law providing for internal revenue, or from revenue from imports or tonnage, except those cases arising under any law providing revenue from imports, jurisdiction of which has been conferred upon the Court of Customs and Patent Appeals. (Mar. 3, 1911, ch. 231, §24, par. 5, 36 Stat. 1092; Mar. 2, 1929, ch. 488, §1, 45 Stat. 1475.)

(6) Suits under postal laws.

Sixth. Of all cases arising under the postal laws. (Mar. 3, 1911, ch. 231, §24, par. 6, 36 Stat. 1092.)

(7) Suits under patent, copyright, and trade-mark laws.

Seventh. Of all suits at law or in equity arising under the patent, the copyright, and the trade-mark laws. (Mar. 3, 1911, ch. 231, §24, par. 7, 36 Stat. 1092.)

(8) Suits under interstate commerce laws.

Eighth. Of all suits and proceedings arising under any law regulating commerce. (Mar. 3, 1911, ch. 231. §24, par. 8. 36 Stat. 1092; Oct. 22, 1913, ch. 32, 38 Stat. 219.)

(9) Penalties and forfeitures.

Ninth. Of all suits and proceedings for the enforcement of penalties and forefeitures incurred under any law of the United States. (Mar. 3, 1911, ch. 231, §24, par. 9, 36 Stat. 1092.)

(10) Suits on debentures.

Tenth. Of all suits by the assignee of any debenture for drawback of duties, issued under any law for the collection of duties, against the person to whom such debenture was originally granted, or against any indorser thereof, to recover the amount of such debenture. (Mar. 3, 1911, ch. 231, §24, par. 10, 36 Stat. 1092.)

(11) Suits for injuries on account of acts done under laws of United States.

Eleventh. Of all suits brought by any person to recover damages for any injury to his person or property on account of any act done by him, under any law of the United States, for the protection or collection of any of the revenues thereof, or to enforce the right of citizens of the United States to vote in the several States. (Mar. 3, 1911, ch. 231, §24, par. 11, 36 Stat. 1092.)

(12) Suits concerning civil rights.

Twelfth. Of all suits authorized by law to be brought by any person for the recovery of damages on account of any injury to his person or property, or of the deprivation of any right or privilege of a citizen of the United States, by any act done in furtherance of any conspiracy mentioned in section 47 of Title 8. (Mar. 3, 1911, ch. 231, §24, par. 12, 36 Stat. 1092.)

(13) Suits against persons having knowledge of conspiracy.

Thirteenth. Of all suits authorized by law to be brought against any person who, having knowledge that any of the wrongs mentioned in section 47 of Title 8, are about to be done, and, having power to prevent or aid in preventing the same, neglects or refuses so to do, to recover damages for any such wrongful act. (Mar. 3, 1911, ch. 231, §24, par. 13, 36 Stat. 1092.)

(14) Suits to redress deprivation of civil rights.

Fourteenth. Of all suits at law or in equity authorized by law to be brought by any person to redress the deprivation, under color of any law, statute, ordinance, regulation, custom, or usage, of any State, of any right, privilege, or immunity, secured by the Constitution of the United States, or of any right secured by any law of the United States providing for equal rights of citizens of the United States, or of all persons within the jurisdiction of the United States. (Mar. 3, 1911, ch. 231, §24, par. 14, 36 Stat. 1092.)

(15) Suits to recover certain offices.

Fifteenth. Of all suits to recover possession of any office, except that of elector of President or Vice President, Representative in or Delegate to Congress, or member of a State legislature, authorized by law to be brought, wherein it appears that the sole question touching the title to such office arises out of the denial of the right to vote to any citizen offering to vote, on account of race, color, or previous condition of servitude. Such jurisdiction shall extend only so far as to deter-

mine the rights of the parties to such office by reason of the denial of the right guaranteed by the Constitution of the United States, and secured by any law, to enforce the right of citizens of the United States to vote in all the States. (Mar. 3, 1911, ch. 231, §24, par. 15, 36 Stat. 1092.)

(16) Suits against national banking associations.

Sixteenth. Of all cases commenced by the United States, or by direction of any officer thereof, against any national banking association, and cases for winding up the affairs of any such bank; and of all suits brought by any banking association established in the district for which the court is held, under the provisions of chapter 2 of Title 12, to enjoin the Comptroller of the Currency, or any receiver acting under his direction, as provided by said chapter. And all national banking associations established under the laws of the United States shall, for the purposes of all other actions by or against them, real, personal, or mixed, and all suits in equity, be deemed citizens of the States in which they are respectively located. (Mar. 3, 1911, ch. 231, §24, par. 16, 36 Stat. 1092.)

(17) Suits by aliens for torts.

Seventeenth. Of all suits brought by any alien for a tort only, in violation of the laws of nations or of a treaty of the United States. (Mar. 3, 1911, ch. 231, §24, par. 17, 36 Stat. 1093.)

(18) Suits against consuls and vice consuls.

Eighteenth. Of all suits against consuls and vice consuls. (Mar. 3, 1911, ch. 231, §24 par. 18, 36 Stat. 1093.)

(19) Suits and proceedings in bankruptcy.

Nineteenth. Of all matters and proceedings in bankruptcy. (Mar. 3, 1911. ch. 231, §24, par. 19, 36 Stat. 1093.)

(20) Suits against United States.

Twentieth. Concurrent with the Court of Claims, of all claims not exceeding $10,000 founded upon the Constitution of the United States or any law of Congress, or upon any regulation of an executive department, or upon any contract, express or implied, with the Government of the United States, or for damages, liquidated or unliquidated, in cases not sounding in tort, in respect to which claims the party would be entitled to redress against the United States, either in a court of law, equity, or admiralty, if the United States were suable, and of all set-offs, counterclaims, claims for damages, whether liquidated or unliquidated, or other demands whatsoever on the part of the Government of the United States against any claimant against the Government in said court; and of any suit or proceeding commenced after the passage of the Revenue Act of 1921, for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or of any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal-revenue laws even if the claim exceeds $10.000, if the collector of internal revenue by whom such tax,

penalty, or sum was collected is dead or is not in office as collector of internal revenue at the time such suit or proceeding is commenced. Nothing in this paragraph shall be construed as giving to either the district courts or the Court of Claims jurisdiction to hear and determine claims growing out of the Civil War, and commonly known as "war claims", or to hear and determine other claims which had been rejected or reported on adversely prior to the 3d day of March 1887 by any court, department, or commission authorized to hear and determine the same, or to hear and determine claims for pensions; or as giving to the district courts jurisdiction of cases brought to recover fees, salary, or compensation for official services of officers of the United States or brought for such purpose by persons claiming as such officers or as assignees or legal representatives thereof; but no suit pending on the 27th day of June 1898 shall abate or be affected by this provision. No suit against the Government of the United States shall be allowed under this paragraph unless the same shall have been brought within six years after the right accrued for which the claim is made. The claims of married women, first accrued during marriage, of persons under the age of twenty-one years, first accrued during minority, and of idiots, lunatics, insane persons, and persons beyond the seas at the time the claim accrued, entitled to the claim, shall not be barred if the suit be brought within three years after the disability has ceased; but no other disability than those enumerated shall prevent any claim from being barred, nor shall any of the said disabilities operate cumulatively. All suits brought and tried under the provisions of this paragraph shall be tried by the court without a jury. (Mar. 3, 1911, ch. 231, §24, par. 20, 36 Stat. 1093; Nov. 23, 1921, ch. 136, §1310 (c), 42 Stat. 311; June 2, 1924, 4:01 p. m., ch. 234, §1025 (c), 43 Stat.

348; Feb. 24, 1925, ch. 309, 43 Stat. 972; Feb. 26, 1926, ch. 27, §§1122 (c), 1200, 44 Stat. 121, 125.)

(21) Suits for unlawful inclosure of public lands.

Twenty-first. Of proceedings in equity, by writ of injunction, to restrain violations of the provisions of laws of the United States to prevent the unlawful inclosure of public lands; and it shall be sufficient to give the court jurisdiction if service of original process be had in any civil proceeding on any agent or employee having charge or control of the inclosure. (Mar. 3, 1911, ch. 231, §24, par. 21, 36 Stat. 1093.)

(22) Suits under immigration and contract labor laws.

Twenty-second. Of all suits and proceedings arising under any law regulating the immigration of aliens, or under the contract labor laws. (Mar. 3, 1911, ch. 231, §24, par. 22, 36 Stat. 1093.)

(23) Suits against trusts, monopolies, and unlawful combinations.

Twenty-third. Of all suits and proceedings arising under any law to protect trade and commerce against restraints and monopolies. (Mar. 3, 1911, ch. 231, §24, par. 23, 36 Stat. 1093.)

(24) Suits concerning allotments of land to Indians; decrees; appeal.

Twenty-fourth. Of all actions, suits, or proceedings involving the right of any person, in whole or in part of

Indian blood or descent, to any allotment of land under any law or treaty.

And the judgment or decree of any such court in favor of any claimant to an allotment of land shall have the same effect, when properly certified to the Secretary of the Interior, as if such allotment had been allowed and approved by him; but this provision shall not apply to any lands held on or before December 21, 1911, by either of the Five Civilized Tribes, the Osage Nation of Indians, nor to any of the lands within the Quapaw Indian Agency. The right of appeal shall be allowed to either party as in other cases. (Mar. 3, 1911, ch. 231, §24, par. 24, 36 Stat. 1094; Dec. 21, 1911, ch. 5, 37 Stat. 46.)

(25) Partition suits where United States is joint tenant.

Twenty-fifth. Of suits in equity brought by any tenant in common or joint tenant for the partition of lands in cases where the United States is one of such tenants in common or joint tenants, such suits to be brought in the district in which such land is situate. (Mar. 3, 1911, ch. 231, §24, par. 25, 36 Stat. 1094.)

(26) Original jurisdiction of bills of interpleader, and of bills in the nature of interpleader.

(a) Of suits in equity begun by bills of interpleader or bills in the nature of bills of interpleader duly verified, filed by any person, firm, corporation, association, or society having in his or its custody or possession money or property of the value of $500 or more, or having issued a note, bond, certificate, policy of insurance, or other instrument of the value or amount of $500 or

more, or providing for the delivery or payment or the loan of money or property of such amount or value, or being under any obligation written or unwritten to the amount of $500 or more, if—

(i) Two or more adverse claimants, citizens of different States, are claiming to be entitled to such money or property, or to any one or more of the benefits arising by virtue of any note, bond, certificate, policy, or other instrument, or arising by virtue of any such obligation; and

(ii) The complainant (a) has deposited such money or property or has paid the amount of or the loan or other value of such instrument or the amount due under such obligation into the registry of the court, there to abide the judgment of the court; or (b) has given bond payable to the clerk of the court in such amount and with such surety as the court or judge may deem proper, conditioned upon the compliance by the complainant with the future order or decree of the court with respect to the subject matter of the controversy.

Such a suit in equity may be entertained although the titles or claims of the conflicting claimants do not have a common origin, or are not identical, but are adverse to and independent of one another.

(b) Such a suit may be brought in the district court of the district in which one or more of such claimants resides or reside.

(c) Notwithstanding any provision of Part I of this title to the contrary, said court shall have power to issue its process for all such claimants and to issue an order of

injunction against each of them, enjoining them from instituting or prosecuting any suit or proceeding in any State court or in any United States court on account of such money or property or on such instrument or obligation until the further order of the court; which process and order of injunction shall be returnable at such time as the said court or a judge thereof shall determine and shall be addressed to and served by the United States marshals for the respective districts wherein said claimants reside or may be found.

(d) Said court shall hear and determine the cause and shall discharge the complainant from further liability; and shall make the injunction permanent and enter all such other orders and decrees as may be necessary or convenient to carry out and enforce the same.

(e) In any action at law in a United States District Court against any person, firm, corporation, association, or society, such defendant may set up by way of equitable defense, in accordance with section 398 of this title, any matter which would entitle such person, firm, corporation, association, or society to file an original or ancillary bill of interpleader or bill in the nature of interpleader in the same court or in any other United States District Court against the plaintiff in such action at law and one or more other adverse claimants, under the provisions of paragraph (a) of this subsection or any other provision of Part I of this title and the rules of court made pursuant thereto. The defendant may join as parties to such equitable defense any claimant or claimants who are not already parties to such action at law. The district court in which such equitable defense is interposed shall thereby possess the powers conferred

upon district courts by paragraphs (c) and (d) of this subsection and by section 398 of this title. (May 8, 1926, ch. 273, §§1-3. 44 Stat. 416; Jan. 20, 1936, ch. 13, §1, 49 Stat. 1096)

(27) Enforcement of orders of Interstate Commerce Commission.

Twenty-seventh. Of all cases for the enforcement of any order of the Interstate Commerce Commission. (Mar. 3, 1911, ch. 231, §207, 36 Stat. 1148; Oct. 22, 1913, ch. 32, 38 Stat. 219.)

(28) Setting aside order of Interstate Commerce Commission.

Twenty-eighth. Of cases brought to enjoin, set aside, annul, or suspend in whole or in part any order of the Interstate Commerce Commission. (Mar. 3, 1911, ch. 231, §24, pars. 1-25, 36 Stat. 1091-1094; Mar. 3, 1911, ch. 231, §207, 36 Stat. 1148; Dec. 21, 1911, ch. 5, 37 Stat. 46; Oct. 22, 1913, ch. 32, 38 Stat. 219; Oct. 6, 1917, ch. 97, §1, 40 Stat. 395; Nov. 23, 1921, ch. 136, §1310 (c), 42 Stat. 311; June 10, 1922, ch. 216, §1, 42 Stat. 634; June 2, 1924, 4:01 p.m., ch. 234, §1025 (c), 43 Stat. 348; Feb. 24, 1925, ch. 309, 43 Stat. 972; Feb. 26, 1926, ch. 27, §§1122 (c), 1200, 44 Stat. 121, 125; May 8, 1926, ch. 273, §§1-3, 44 Stat. 416; Mar. 2, 1929, ch. 488, §1, 45 Stat. 1475; May 14, 1934, ch. 283, §1, 48 Stat. 775; Jan. 20, 1936, ch. 113, §1, 49 Stat. 1096; Aug. 21, 1937, ch. 726, §1, 50 Stat. 738; Apr. 20, 1940, ch. 117, 54 Stat. 143.)

42 U.S.C.A. §405(g) (1974)

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time,

on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

42 U.S.C.A. §1395ff (1974)

§1395ff. Determinations; appeals

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

Aug. 14, 1935, c. 531, Title XVIII, §1869, as added July 30, 1965, Pub.L. 89-97, Title I, §102(a), 79 Stat. 330, and

amended Oct. 30, 1972, Pub.L. 92-603, Title II, §2990(a), 86 Stat. 1464.

20 C.F.R. §405.486(b) (1) (1977)

(b) *Billing for physician services.* (1) The objective in determining reasonable charges where the physician bills patients directly is the same as that expressed in §405.485(a): to bring about as little change as possible (in the normal case) in the compensation the physician receives for his services in the hospital. Where the physician bills the patient directly, costs of operating the hospital department which are borne by the physician will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program; the hospital will receive reimbursement through the hospital insurance program for those costs, if any, which it incu[illegible]. Where, however, a hospital initially pays some or [illegible] operating expenses of a hospital department [illegible]s the salaries of nonprofessional personne[illegible] purchases supplies and equipment), even thou[illegible]n subsequently those items and services for which it pay[illegible] the operating expenses are furnished for the use of the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimbursable under the hospital insurance program as hospital costs, and are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program.

No. 78-88

In the Supreme Court of the United States

OCTOBER TERM, 1978

DR. JOHN T. MACDONALD FOUNDATION, INC., d/b/a DOCTORS' HOSPITAL, A FLORIDA CORPORATION NOT FOR PROFIT, PETITIONER

v.

JOSEPH A. CALIFANO, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MEMORANDUM FOR THE RESPONDENTS

WADE H. MCCREE, JR.
Solicitor General
Department of Justice
Washington, D.C. 20530

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OPINIONS BELOW

The *en banc* opinion of the court of appeals (Pet. App. 1-12) is reported at 571 F.2d 328. The first opinion of the panel (Pet. App. 24-36) and the opinion of the panel on rehearing (Pet. App. 13-23) are reported at 534 F.2d 633 and 554 F.2d 714. The

opinion of the district court (Pet. App. 37-46) is unreported. The opinions of the Secretary's delegates (Pet. App. 47-53) are not reported.

JURISDICTION

The judgment of the court of appeals was entered on April 17, 1978. The petition for a writ of certiorari was filed on July 15, 1978. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTIONS PRESENTED

1. Whether 42 U.S.C. 405(h) precludes review by district courts of determinations by the Secretary of Health, Education, and Welfare regarding computation of the amount owed petitioner for the reasonable cost of medical services it performed as a Medicare provider.

2. Whether the Court of Claims has jurisdiction, pursuant to 28 U.S.C. 1491, to review the Secretary's determinations.

STATEMENT

The Health Insurance For The Aged Act (commonly known as the Medicare Act), 42 U.S.C. 1395 *et seq.*, requires the Secretary of Health, Education, and Welfare to reimburse qualified "providers" for the "reasonable cost" of the medical services they furnish to eligible Medicare beneficiaries. 42 U.S.C. 1395g, 1395f(b). The Act provides that the reasonable cost of such services "shall be determined in accordance with regulations establishing the method

or methods to be used * * * in determining such costs." 42 U.S.C. 1395x(v)(1).[1]

The Secretary has promulgated 20 C.F.R. 405.486 (b)(1), a regulation governing, *inter alia*, the computation of reasonable costs to be allowed a provider hospital for its medical services when the hospital receives income through leasing one or more of its departments to physicians who are separately reimbursed under the Act for reasonable charges made for their services. The regulation specifies that any income "received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program."

Petitioner, a general short-term hospital, became a provider of Medicare services in 1966. In fiscal years 1967 and 1968 petitioner leased its radiology department to three physicians, providing them with utilities and certain maintenance services and receiving from them payments based on a percentage of revenue taken in by the department. In fiscal years 1969 through 1972 petitioner leased the department to the same physicians on a different basis: petitioner assumed the department's operating costs and received a fixed fee plus a percentage of revenues in return. The lease arrangement generated net income for petitioner during each of the fiscal years 1967-1972.

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[1] Except where noted otherwise, references to the Medicare Act are to provisions in the 1970 edition of the United States Code, which governed the claims at issue here.

As a provider of services, petitioner is required to file annual cost reports with the Blue Cross Association (BCA), and Blue Cross of Florida (BCF), its designated fiscal intermediaries, to supply a basis for determining the amounts properly reimbursable for its services under the Act.[2] For each of the fiscal years 1967-1972, BCF determined that the amounts claimed by petitioner for its services should be reduced by setting off the Medicare portion of the net income generated by the radiology department lease against petitioner's otherwise reimbursable costs for its entire hospital facility.[3] Petitioner appealed this determination for fiscal years 1967 and 1968 to the Blue Cross Association Medicare Provider Appeal Committee, which, after a hearing, upheld the determination as a proper application of 20 C.F.R. 405.486 (b)(1) (Pet. App. 47-49). On a subsequent appeal on the same issue with respect to fiscal years 1969-

[2] 42 U.S.C. 1395h permits the Secretary to appoint public or private agencies, known as fiscal intermediaries, to administer Medicare payments as agents for the Secretary. Pursuant to that provision, the Secretary's regulations provide (20 C.F.R. 405.651(c)): "[F]iscal intermediaries act on behalf of the Secretary, carrying on for him the administrative responsibilities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program."

[3] The "Medicare portion" is the portion equivalent to the percentage of Medicare utilization of the hospital facilities. This calculation must be made because of the requirement in 42 U.S.C. 1395x(v)(1) that the Secretary take care to avoid placing the burden of Medicare costs on individuals not covered by Medicare.

1972, the Committee reached the same decision (Pet. App. 50-53).

Petitioner then instituted this action against the Secretary[4] in the United States District Court for the Southern District of Florida, asking the court to declare either (a) that the regulation in question requires only an offset of payments received from the radiology department lessees against petitioner's costs in connection with the department or (b) that the regulation as interpreted by the Secretary is void because it conflicts with the Medicare Act. Petitioner also sought an order requiring the Secretary to recompute the amounts owing to petitioner in fiscal years 1967-1972 without making the challenged offset.

The district court found that it had jurisdiction under the Administrative Procedure Act (APA), 5 U.S.C. 701-706, and upheld both the Secretary's interpretation of the regulation and its validity under the statute (Pet. App. 37-46). A panel of the court of appeals agreed that the APA supplied jurisdiction, but it reversed the district court's decision on the merits, holding that the Secretary abused his discretion by applying 20 C.F.R. 405.486(b)(1) to require a reduction in provider reimbursement (Pet. App. 24-36). The Secretary filed a timely petition for rehearing on the jurisdictional issue, but the court withheld ruling on it until after this Court decided *Califano* v. *Sanders*, 430 U.S. 99 (1977). The panel, with Judge Clark dissenting, then denied the petition

[4] References to "the Secretary" include the designated intermediaries.

for rehearing and held that, although *Sanders* precluded resting jurisdiction on the APA, jurisdiction nonetheless lies under 28 U.S.C. 1331 (Pet. App. 13-23).

The Secretary obtained leave to file a second petition for rehearing, with suggestion of rehearing *en banc*, which the court granted. The *en banc* court held that 42 U.S.C. 405(h) precludes all review in the district courts of pre-1973 reimbursement decisions of the Secretary.[5] The court observed, however, that the Court of Claims, in cases such as *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (1976), cert. denied, 430 U.S. 969 (1977), had held that it had jurisdiction under the Tucker Act, 28 U.S.C. 1491, to decide pre-1973 reimbursement disputes. Stating that this was "a holding that we are powerless to overturn" (Pet. App. 8), the court of appeals transferred the case directly to the Court of Claims pursuant to 28 U.S.C. 1406(c).

DISCUSSION

1. The court of appeals correctly determined that the district court had no jurisdiction to review these pre-1973 Medicare reimbursement claims.

Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), is incorporated into the Medicare Act

[5] The Act was amended in 1972 (86 Stat. 1422) and 1974 (88 Stat. 1459) to provide for judicial review of claims arising in accounting periods after June 30, 1973.

by 42 U.S.C. 1395ii.[6] The second sentence of Section 405(h) provides:

> No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.

This Court noted in *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975) (emphasis added), that Section 405 (h) "prevent[s] review of decisions of the Secretary *save as provided in the Act*" and that "sources of jurisdiction [outside the Act are] foreclosed by § 405 (h)" (*id.* at 764).

With respect to most Social Security claims the "herein provided" clause of Section 405(h) refers to Section 405(g), which generally provides for judicial review of "any final decision of the Secretary made after a hearing." See *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 763-764.[7] But when Congress enacted the Medicare Act, it chose not to incorporate Section 405 (g). Instead Congress limited review of administrative actions under the Medicare Act to specific categories of disputes, not including reimbursement claims

[6] 42 U.S.C. 1395ii provides:

> The provisions of sections 406, 408, and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k) and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

[7] For purposes of this provision, "decision of the Secretary" includes the decision of his statutory delegate, such as, in this case, the Provider Appeal Committee.

by Medicare providers. See 42 U.S.C. 1395ff.[8] The limitation of review to specific categories of disputes was careful and deliberate. See S. Rep. No. 404, 89th Cong., 1st Sess. 54-55 (1965).

The 1972 and 1974 amendments to the review provisions of the Medicare Act support the conclusion that Section 405(h) precludes judicial review of respondent's claim for reimbursement. In 1972 Medicare providers urged Congress to lift the Act's barriers to judicial review. See, *e.g.*, *Hearings on H.R. 17550 Before the Senate Committee on Finance*, 91st Cong., 2d Sess. 679-701 (1970). In response, Congress established both a "Provider Reimbursement Review Board," and, for the first time, a limited right to judicial review for reimbursement disputes. Social Security Amendments of 1972, 42 U.S.C. (1970 ed., Supp. II) 1395*oo*. In 1974 the Act was further amended to provide judicial review for most Medicare provider disputes. 42 U.S.C. (Supp. V) 1395*oo*. In both instances, however, judicial review was made available only with respect to accounting periods ending *on or after* June 30, 1973. Thus Congress carefully considered the question of judicial review of Medicare provider reimbursement controversies, and it clearly understood and intended judicial review to be precluded for disputes, such as this one, involving pre-1973 periods.

[8] The categories of disputes for which the Act initially provided judicial review were claims by Medicare beneficiaries concerning entitlement to and the amount of benefits under Parts A and B of the Act and claims by providers concerning their status as providers and the termination of that status.

Petitioner is incorrect in contending (Pet. 18-20) that the *en banc* decision of the court of appeals conflicts with cases decided by other circuits after this Court's decisions in *Weinberger* v. *Salfi*, *supra*, and *Califano* v. *Sanders*, *supra*. The decisions on which petitioner relies (Pet. 18-19) concern the existence, extent, and basis of district court jurisdiction to review substantial constitutional issues—most notably claims of a denial of procedural due process—in Medicare reimbursement disputes not subject to the review procedures provided in the 1972 and 1974 amendments.[9] None, however, holds that district courts have jurisdiction over disputes, like the one presented here, concerning the proper interpretation of regulations and their application to the facts in a

[9] Five circuits have indicated that Section 405(h) does not preclude district court review of procedural due process claims in Social Security Act or Medicare Act cases, but they differ about the basis of jurisdiction. *Cervoni* v. *Secretary of Health, Education, and Welfare*, No. 77-1345 (1st Cir. June 27, 1978), slip op. 13-14 (jurisdiction based on 28 U.S.C. 1331) (dictum); *White* v. *Mathews*, 559 F.2d 852, 855-856 (2d Cir. 1977), cert. denied, No. 77-866 (Feb. 27, 1978) (28 U.S.C. 1361); *St. Louis University* v. *Blue Cross Hospital Service, Inc.*, 537 F.2d 283, 291-292 (8th Cir. 1976), cert. denied, 429 U.S. 977 (1976) (28 U.S.C. 1331); *Elliott* v. *Weinberger*, 564 F.2d 1219 (9th Cir. 1977) (28 U.S.C. 1361), petition for cert. pending, No. 77-1511; *Association of American Medical Colleges* v. *Califano*, 569 F.2d 101, 113 (D.C. Cir. 1977) (28 U.S.C. 1361) (dictum). The Seventh Circuit has held that district courts are barred by Section 405(h) from considering constitutional claims in pre-1973 Medicare provider reimbursement disputes. *Trinity Memorial Hospital* v. *Associated Hospital Service*, 570 F.2d 660, 667 (1977).

particular case.[10] Moreover, at least four post-*Salfi* decisions, like the *en banc* decision here, squarely hold that district courts lack jurisdiction over such non-constitutional questions. *Trinity Memorial Hospital* v. *Associated Hospital Service*, 570 F.2d 660, 666 (7th Cir. 1977); *Cervoni* v. *Secretary of Health, Education, and Welfare*, No. 77-1345 (1st Cir. June 27, 1978), slip op. 9-13, 18-19; *St. Louis University* v. *Blue Cross Hospital Service, Inc.*, 537 F.2d 283, 287-289 (8th Cir. 1976), cert. denied, 429 U.S. 977 (1976); *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910, 913 (2d Cir. 1976).

2. Although the court of appeals properly held that the district court had no jurisdiction, we believe that it erred in transferring the case to the Court of Claims. The court transferred the case on the authority of 28 U.S.C. 1406(c), which provides that "[i]f a case within the exclusive jurisdiction of the Court of Claims is filed in a district court, the district court shall, if it be in the interest of justice, transfer such case to the Court of Claims * * *." Even if a court of appeals, as well as a district court,

[10] Petitioner made no constitutional claim in the district court, but it suggests now (Pet. 24-25) that it is entitled by the Constitution to judicial review of the Secretary's determination that radiology department income must be used to offset overall hospital costs. This contention is groundless, for where, as here, there is "clear and convincing" evidence of a congressional intent to foreclose judicial review of such claims, the Constitution does not require judicial review. *Califano* v. *Sanders, supra*, 430 U.S. at 109; *Weinberger* v. *Salfi, supra*, 422 U.S. at 762.

may transfer cases pursuant to this provision (see *Panhandle Eastern Pipe Line Co.* v. *Federal Power Commission*, 343 F.2d 905, 908-909 (8th Cir. 1965)), the court of appeals nonetheless lacked power to make the transfer here because the case is not "within the exclusive jurisdiction of the Court of Claims" and hence does not meet the requirements of 28 U.S.C. 1406(c). For the reasons stated at pages 6-8, *supra*, Section 405(h) precludes review by *any* court of disputes of the kind presented here.

The Court of Claims has held that the Tucker Act, 28 U.S.C. 1491, gives it jurisdiction to hear Medicare provider reimbursement disputes.[11] See, *e.g.*, *Appalachian Regional Hospitals, Inc.* v. *United States*, 576 F.2d 858 (1978); *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (1976), cert. denied, 430 U.S. 969 (1977). This position, however, is inconsistent not only with the plain language of Section 405(h) but also with the principle that the Court of Claims cannot enter money judgments against the United States

[11] 28 U.S.C. (Supp. V) 1491 provides in pertinent part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. * * * In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just.
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> * * * * *

unless Congress has clearly authorized it to do so. Waivers of sovereign immunity from suits for money damages, which would give rise to Court of Claims jurisdiction under the Tucker Act, " 'cannot be implied but must be unequivocally expressed.' " *United States* v. *Testan*, 424 U.S. 392, 399 (1976), quoting from *United States* v. *King*, 395 U.S. 1, 4 (1969). The Medicare Act contains no provision indicating an intent to waive sovereign immunity to actions by Medicare providers, such as petitioner, for additional payments under the Act. Indeed, the inclusion of Section 405(h) in the Act indicates precisely the contrary.

We therefore adhere to the view, expressed in our petition for certiorari in *Whitecliff, Inc.* v. *United States*, *supra*, that the Court of Claims cannot hear Medicare provider disputes. Moreover, we believe that the issue continues to be important. The Secretary estimates that nearly two hundred Medicare cases not covered by any review provision in the Social Security Act or the Medicare Act either are pending in the Court of Claims or are pending in the district courts and susceptible to transfer to the Court of Claims by courts that decide to follow the holding in this case.[12] Those cases involve claims totaling more

[12] Of those two hundred cases, approximately 45 involve pre-1973 Medicare provider disputes. The Secretary also informs us that thousands more Medicare cases not subject to Social Security Act or Medicare Act review provisions are now being handled administratively. Moreover, even cases involving disputes governed by such review provisions may be affected, since the aggrieved parties might well seek to evade time and amount-in-controversy limitations by filing under 28 U.S.C. 1491 in the Court of Claims.

than $20 million. Courts continue to express uncertainty concerning whether the Court of Claims has jurisdiction to hear such cases[13] and, if so, what the scope of that jurisdiction is.[14]

We did not file a petition for a writ of certiorari to review the transfer order in this case because the Court, in denying our petition for a writ of certiorari in *Whitecliff*, apparently determined that the question of the Court of Claims' jurisdiction does not warrant review. If the Court should decide, however, that it is now appropriate to examine the extent of the Court of Claims' jurisdiction, then it can do so in the present case. The jurisdiction of the court of appeals to transfer the case depends on 28 U.S.C. 1406(c), and Section 1406(c) makes the authority to transfer depend on the jurisdiction of the Court of Claims. Although the court of appeals thought (see Pet. App. 8) that it was powerless to disagree with the Court of Claims' assertion of jurisdiction, this Court is not similarly bound. Moreover, because the issue goes to the jurisdiction of both the transferor court and the

[13] In *Sierra Vista Hospital, Inc.* v. *Califano*, No. 75-2738 (9th Cir. argued Aug. 10, 1978), the court has ordered the proceeding held in abeyance and directed the government to advise it concerning further developments in this case.

[14] Compare *Trinity Memorial Hospital* v. *Associated Hospital Service*, *supra*, 570 F.2d at 667 (jurisdiction over procedural due process claims), with *South Windsor Convalescent Home, Inc.* v. *Mathews*, *supra*, 541 F.2d at 914 (no limitation specified) and *Whitecliff, Inc.* v. *United States*, *supra*, 536 F.2d at 351 (jurisdiction to review compliance with Constitution and governing statute).

transferee court, it may be reviewed here even though we have not filed a petition for certiorari. See, *e.g.*, *Abney* v. *United States*, 431 U.S. 651 (1977); *Liberty Mutual Insurance Co.* v. *Wetzel*, 424 U.S. 737 (1976).

CONCLUSION

We do not oppose the granting of the petition for a writ of certiorari.

Respectfully submitted.

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Solicitor General

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